

00-13725

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Clifford	MIDDLE G.	LAST Melton, SR	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 6:00 P.M.		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 3 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. Co., MD					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professional		12b. KIND OF BUSINESS OR INDUSTRY Ball Player			
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1525 Argonne Dr. 21208			
14. FATHER'S NAME FIRST MIDDLE LAST Charles D. Melton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Callie Mease							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 120-03-8827		17. INFORMANT ADDRESS Mrs. Mary A. Melton 1525 Argonne Dr. -18					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of Colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/24 1986, to 7/28 1986, that (I) (we) last saw the deceased alive on 7/28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lester A. Wall Jr. M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESTER A. WALL JR. M.D.				22e. ADDRESS 7620 York Rd Towson MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/86		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR JUL 29 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

18950

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William R. Menzel			2a. DATE OF DEATH MONTH DAY YEAR July 2, 1986		2b. HOUR 8:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 31 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1921 Ellinwood Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Balto Transit Co.	
13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1921 Ellinwood Rd. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST William Menzel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McGaw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-10-1094		17. INFORMANT ADDRESS Lillian Menzel (wife) same address	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melastatic bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. Milner</i>		DEGREE Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>			22c. DATE SIGNED 7/2/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sheldon Milner		22e. ADDRESS 404 Eastern Blvd 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/5/86	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto Md. 21213			25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE JUL 3 - 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-12667

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank J. Mikulski			2a. DATE OF DEATH MONTH DAY YEAR 7/14/86		2b. HOUR 7:30 P
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10/10/13		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. STREET ADDRESS / ZIP CODE 2701 Eastern Ave. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MIKULSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE RATAJCZAK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216327550		17. INFORMANT ADDRESS DEBORAH Mikulski 2701 Eastern Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Esophageal Ca. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY	
BURIAL	7-18-1986	HOLY ROSARY		BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.		25. DATE REC'D. BY REGISTRAR JUL 17 1986	



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00-12746

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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 DHMH - 16 60M 7/84  
 (VRA 15, 4)

 1- FOR  
 STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine, m. Miller			2a. DATE OF DEATH 7/12/86		2b. HOUR 3:50 PM	
3. SEX Female		4. RACE White-		5. DATE OF BIRTH 6 11 04		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
13a. USUAL RESIDENCE (IF NURSING HOME, GIVE RESIDENTIAL ADDRESS) Md. XXXXXXXX		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Charles A. Miller		15. MOTHER'S MAIDEN NAME Mary Patterson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b. SOCIAL SECURITY NO. 212-10-0999A		17. INFORMANT Sara L. McFaul, 6059 Harford Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHF.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-12, 1986, to 7-12, 1986, that (I) (we) last saw the deceased alive on 7-12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R. Mitra MD.		DEGREE MD.		22c. DATE SIGNED 7/12/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUPAK C. MITRA, MD		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		
23d. LOCATION CITY OR TOWN Parkville, Balto., Md.		23e. COUNTY BALTIMORE		23f. STATE MD.		
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214		25. DATE REC'D. BY REGISTRAR JUL 17 1986		25b. REGISTRAR'S SIGNATURE		

BP

Handwritten notes and markings at the top of the page, including the word "Faint" and other illegible scribbles.

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00-12343

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 18953

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emory S Miller			2a. DATE OF DEATH MONTH DAY YEAR 7 12 86			2b. HOUR 10 <sup>55</sup> A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 11 01		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris 2300 Dulaney Valley Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROJECT MANAGER CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John T Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Cain		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 213-03-7369		17. INFORMANT ADDRESS JOHN E. MILLER 1634 GLEN KEITH BLVD. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-9 1986, to 7/12 1986, that (I) (we) lost saw the deceased alive on 7/12 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kendall R. Faulkner, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner, M.D.		22e. ADDRESS Stella Maris Hospice 2300 Dulaney Valley Rd.-Towson, MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 16, '86		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY BALTIMORE, MARYLAND		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		ADDRESS 8521 LOCH RAVEN BLVD.		25a. DATE REC'D. BY REGISTRAR JUL 14 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR COTTON  
FIBER  
COTTON

00-12673

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

18954

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN M. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 15, 1986</b>		2b. HOUR <b>3:26 A.M.</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 1, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3 E. Hiawatha Court</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3 E. Hiawatha Ct. 21117</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl Hartman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Oliver Little</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>107-03-5973A</b>		17. INFORMANT ADDRESS <b>Joan Y. Lang - 3911 McDonough Rd. 21133</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma with ascites</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 23</b> , 19 <b>86</b> , to <b>July 15</b> , 19 <b>86</b> , that (II) (we) last saw the deceased alive on <b>June 17</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. M. Newman M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>7-15-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary M. Newman, M.D.</b>				22e. ADDRESS <b>9 E. Chase Street Baltimore, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-18-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Swider</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completed, if applicable) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies from page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.				7 8 9 5 5			
1. DECEASED NAME (TYPE OR PRINT) =HENRY MILLER					2a. DATE OF DEATH MONTH DAY YEAR JULY 20, 1986			2b. HOUR 5:55 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 15, 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY AT LAW	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4007 FALLSTAFF RD. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM MILLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LENA WHITE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-26-4567A		17. INFORMANT ADDRESS MRS. ROSE MILLER 4007 FALLSTAFF RD. 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Shy Drift Abscess</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/14/81</u> , 19____, to <u>7/20/86</u> , 19____, that (I/we) lost saw the deceased alive on <u>7/21/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph Shear</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/21/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LEON SHEER JOSEPH SHEAR				22e. ADDRESS 6715 PARK HEIGHTS AVE.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/21/86		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE REC'D. BY REGISTRAR JUL 25 1986		25b. REGISTRAR'S SIGNATURE			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1 8 9 5 0	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph C MILLER Sr.					2a. DATE OF DEATH MONTH DAY YEAR JULY 2, 1986			2b. HOUR 4:21 P <sub>M</sub>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 2 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drug Company		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2159 Vailthorn Rd. 21220			
14. FATHER'S NAME FIRST MIDDLE LAST William Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Kerner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW11 217-16-8312		17. INFORMANT ADDRESS Ruth Miller 2159 Vailthorn Road 21220							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from July 2, 1986, to July 2, 1986, that (we) lost the deceased alive on July 2, 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Isadore L. Feldman				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Isadore Feldman, MD.,				22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/7/86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Rossville Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221					25a. DATE REC'D. BY REGISTRAR JUL 8 1986		25b. REGISTRAR'S SIGNATURE Julia K. ...				

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 18957  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Shirley R. Milligan</b>			2a DATE OF DEATH MONTH <b>7</b> DAY <b>5</b> YEAR <b>86</b>			2b HOUR <b>12:55 PM</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>18</b> YEAR <b>09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICE WORK</b>		12b KIND OF BUSINESS OR INDUSTRY <b>ALLIED BENDIX</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>			13b COUNTY <b>Balto</b>		13c CITY OR TOWN <b>Cockeysville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>25 Lake Ridge Place 21230</b>		
14 FATHER'S NAME FIRST <b>ALBERT</b> MIDDLE <b>L.</b> LAST <b>REICH</b>			15 MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>PORTER</b> LAST <b>BUTTS</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>A14-22 8140</b>			17 INFORMANT <b>FAMILY RECORDS</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probably Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Ch of left lung</b> (b) <b></b> (c) <b></b> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 10</b>			21c HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from <b>8/14</b> 19 <b>86</b> to <b>7/5</b> 19 <b>86</b> that (we) last saw the deceased alive on <b>7/5</b> 19 <b>86</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) sign this record after death.											
22b SIGNATURE <b>Samuel C. H. Lee, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED <b>7/6/86</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS <b>St. Jos Ho-p. Towson, MD 21204</b>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b DATE <b>7-8-1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNTAIN</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>				
24 FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b>			ADDRESS <b>2325 YORK ROAD</b>			25a DATE REC'D. BY REGISTRAR <b>7/14/86</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic cause, the medical examiner must be notified if and when possible.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 18958	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES LEON MILWAY					2a. DATE OF DEATH MONTH DAY YEAR 7 22 86			2b. HOUR 5:15pm			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 24 17		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH Carney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9707 Oakdale Avenue 21234				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assemblyman		12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.			
13a. STATE Carney			13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE 9707 Oakdale Ave. 21234				
14. FATHER'S NAME FIRST MIDDLE LAST James Hall Milway			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Doyle								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT 217-07-3430		ADDRESS Shirley Milway 9707 Oakdale Ave. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Peripheral Vascular Disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Marion Kowalewski M.D.						DEGREE M.D.			22c. DATE SIGNED 7-24-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marion Kowalewski, M.D.						22e. ADDRESS 8604 Harford Rd. Balto., Md. (668-7030)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-26-86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Lassahn Funeral Home 7401 Calver Rd. Balto. Md. 21234											
DATE REC'D. BY REGISTRAR JUL 28 1986											
25b. REGISTRAR'S SIGNATURE John J. Anderson											

82 P 81

2

82 P 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, sign any injury, or other traumatic event, the medical examiner must be notified or called.

Item 13e. 618 8/7/86 cw		STATE OF MARYLAND		86 18959	
1 - FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Walter F. MISTERKA				July 14, 1986	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		White		6 27 17	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		USA		69 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Rossville		Franklin Square Hospital		Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS / ZIP CODE	
Metal Finisher		GMC		413 Meadow Rd. 5601 McCormick Avenue 21206	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
John Misterka		Susan Motz		Yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218-14-2176		Alexander A. Misterka		1512 Weyburn Rd. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				1 - 5 min	
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF (b) ARTEROSCLEROSIS				YES.	
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION				YES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				OBESITY.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/14/86, 19, to 7/14/86, 19, that (I) (we) lost saw the deceased alive on 7/14/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE (CENTERS) M.D.		22c. DATE SIGNED 7/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. Centers (247-9300)		Rosedale Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-18-86		Parkwood Cemetery	
23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Baltimore, Maryland		7/18/86		John A. ...	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Lassahn Funeral Home		7401 Belair Rd. BALTO, MD. 21236		7/18/86	

P2P81

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000

1

TO : SAC, NEW YORK (100-100000)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with multiple lines of text, some of which are circled or underlined.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARION BEE MITCHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7/27/86</b>			2b. HOUR <b>12:05 M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 01 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELEVATOR OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MITCHELL</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16a. SOCIAL SECURITY NO <b>249-34-0722</b>			17. MRS. <b>MOZELLE MITCHELL</b>			ADDRESS <b>3104 WINDSOR AVENUE BALTIMORE, MARYLAND 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cornary Heart Disease / Duallets Mallets</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>86</b> , to <b>7/27</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jerome H. Ginsberg M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEROME H. GINSBERG M.D.</b>						22e. ADDRESS <b>8630 LIBERTY PLAZA MALL RANDALLSTOWN, MD. 21133</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>8/1/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>NUMMER &amp; SONS FUNERAL HOME, INC.</b> ADDRESS <b>2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1986</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is completed, item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 84 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 18961

1. DECEASED NAME (TYPE OR PRINT) George A. MONIUSZKO			2a. DATE OF DEATH MONTH DAY YEAR July 2, 1986		2b. HOUR 5:35a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 22 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b. KIND OF BUSINESS OR INDUSTRY B. & O. RR	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Moniuszko			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Lencheski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 176-16-9147		17. INFORMANT ADDRESS Irene Moniuszko 7114 Greenwood Ave. 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatic heart disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u> <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>11-25</u> , 19 <u>85</u> , to <u>July 2</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>11-25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Nicholas J. Fortuin</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>7-2-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Fortuin, M.D.		22e. ADDRESS 9 E. Chase Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-5-86	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. DATE REC'D. BY REGISTRAR JUL 08 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Terdiman-Rudner</u>	

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#21b,t, FilmG618 8/7/86  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 18962

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR	
Missouri		W		Moore				July 17 1986		17		86		1986	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
Female	White	7-22-09		76						July 17 1986		17		86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD		USA		WIDOWED		DIVORCED		Baltimore County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
TOWson		St Joseph Hospital		Sales Lady											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		305 E. Joppa Rd. apt. 607							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Loudy		Katherine													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
no		212-03-2812		Nancy L. Moore		3230 Southern Ave. 21244									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
8199		Immediate Cause (a) Cardiac Arrest		Sudden											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b) ASCVD, Mild		5+ yrs											
		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Fractured Left Tibia		Fractured Rt Hip											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
7/17/86		Replacement of Rt Hip		Hospital done 7-18-86											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED											
March 19 86		3:00 A.M.		In auto accident											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY		21f. LOCATION											
		Street		305 E Joppa Rd Towson Baltimore											
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		EXAMINER'S NAME		DATE SIGNED											
Charles J. Donnell		M.D. Deputy		7/17/86											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Burial		7-21-86		Baltimore National		Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Leonard J. Ruck, Inc. 5305 Harford Rd. 21214		JUL 21 1986		Julia Davidson											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1896

0-1-03

Salisbury

1896

205 E. 10th St. No. 101

Town

Salisbury

1896

Salisbury

Salisbury

Salisbury

Salisbury

2144 Southern Ave. 2144

2144-03-2144

2144

Salisbury, Maryland

Salisbury National

7-21-06

Salisbury

Leonard J. Cook, Inc. 2144

00-13439

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA FITZPATRICK MULLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 22, 1986</b>			2b. HOUR <b>4:45 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bradshaw</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8328 Bradshaw Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY _____	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Upper Falls</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7923 Bradshaw Road 21156</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip James Fitzpatrick</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Carr</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-36-3052</b>		17. INFORMANT Address <b>Bradshaw, Md. 21021</b> <b>Margaret A. Baumner, 8328 Bradshaw Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe com. Cereb. A7.6</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>86</b> , to _____, 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Home</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V.S. NORTON M.D.</b>						22e. ADDRESS <b>2112 Belair Road, Jellison, MD 21094</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 25, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bradshaw Balto Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Page 1 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Date		Description		Amount	
Jan 1		Balance		100.00	
Jan 5		Received from A. B.		50.00	
Jan 10		Received from C. D.		25.00	
Jan 15		Received from E. F.		75.00	
Jan 20		Received from G. H.		100.00	
Jan 25		Received from I. J.		150.00	
Jan 30		Received from K. L.		200.00	
Feb 1		Received from M. N.		250.00	
Feb 5		Received from O. P.		300.00	
Feb 10		Received from Q. R.		350.00	
Feb 15		Received from S. T.		400.00	
Feb 20		Received from U. V.		450.00	
Feb 25		Received from W. X.		500.00	
Feb 30		Received from Y. Z.		550.00	
Mar 1		Received from A. B.		600.00	
Mar 5		Received from C. D.		650.00	
Mar 10		Received from E. F.		700.00	
Mar 15		Received from G. H.		750.00	
Mar 20		Received from I. J.		800.00	
Mar 25		Received from K. L.		850.00	
Mar 30		Received from M. N.		900.00	
Apr 1		Received from O. P.		950.00	
Apr 5		Received from Q. R.		1000.00	
Apr 10		Received from S. T.		1050.00	
Apr 15		Received from U. V.		1100.00	
Apr 20		Received from W. X.		1150.00	
Apr 25		Received from Y. Z.		1200.00	
Apr 30		Received from A. B.		1250.00	
May 1		Received from C. D.		1300.00	
May 5		Received from E. F.		1350.00	
May 10		Received from G. H.		1400.00	
May 15		Received from I. J.		1450.00	
May 20		Received from K. L.		1500.00	
May 25		Received from M. N.		1550.00	
May 30		Received from O. P.		1600.00	
Jun 1		Received from Q. R.		1650.00	
Jun 5		Received from S. T.		1700.00	
Jun 10		Received from U. V.		1750.00	
Jun 15		Received from W. X.		1800.00	
Jun 20		Received from Y. Z.		1850.00	
Jun 25		Received from A. B.		1900.00	
Jun 30		Received from C. D.		1950.00	
Jul 1		Received from E. F.		2000.00	
Jul 5		Received from G. H.		2050.00	
Jul 10		Received from I. J.		2100.00	
Jul 15		Received from K. L.		2150.00	
Jul 20		Received from M. N.		2200.00	
Jul 25		Received from O. P.		2250.00	
Jul 30		Received from Q. R.		2300.00	
Aug 1		Received from S. T.		2350.00	
Aug 5		Received from U. V.		2400.00	
Aug 10		Received from W. X.		2450.00	
Aug 15		Received from Y. Z.		2500.00	
Aug 20		Received from A. B.		2550.00	
Aug 25		Received from C. D.		2600.00	
Aug 30		Received from E. F.		2650.00	
Sep 1		Received from G. H.		2700.00	
Sep 5		Received from I. J.		2750.00	
Sep 10		Received from K. L.		2800.00	
Sep 15		Received from M. N.		2850.00	
Sep 20		Received from O. P.		2900.00	
Sep 25		Received from Q. R.		2950.00	
Sep 30		Received from S. T.		3000.00	
Oct 1		Received from U. V.		3050.00	
Oct 5		Received from W. X.		3100.00	
Oct 10		Received from Y. Z.		3150.00	
Oct 15		Received from A. B.		3200.00	
Oct 20		Received from C. D.		3250.00	
Oct 25		Received from E. F.		3300.00	
Oct 30		Received from G. H.		3350.00	
Nov 1		Received from I. J.		3400.00	
Nov 5		Received from K. L.		3450.00	
Nov 10		Received from M. N.		3500.00	
Nov 15		Received from O. P.		3550.00	
Nov 20		Received from Q. R.		3600.00	
Nov 25		Received from S. T.		3650.00	
Nov 30		Received from U. V.		3700.00	
Dec 1		Received from W. X.		3750.00	
Dec 5		Received from Y. Z.		3800.00	
Dec 10		Received from A. B.		3850.00	
Dec 15		Received from C. D.		3900.00	
Dec 20		Received from E. F.		3950.00	
Dec 25		Received from G. H.		4000.00	
Dec 30		Received from I. J.		4050.00	
Total				4100.00	

00-11651

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18964	
1. DECEASED NAME (TYPE OR PRINT)		FIRST EMMA		MIDDLE		LAST MUNDERLOH		2a. DATE OF DEATH		MONTH 7 DAY 7 YEAR 86 2b. HOUR 4:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7101 A Rolling Bend Road 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Otto Wekenmann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Vogel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 214-01-6586D		17. INFORMANT Muriel J. Warner		ADDRESS 312 Westowne Road Baltimore, MD. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Atherosclerotic Heart disease, Renal failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jasneem Lakhan		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/8/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASNEEM LAKHANI				22e. ADDRESS 4220 PARK HEIGHTS AVE, BALD MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR JUL 8 1986		25b. REGISTRAR'S SIGNATURE June Davidson-Henderson			

BP

1000

12-11

RECEIVED

12-11-1911



1000

00-13874

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the coroner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 18965  
REG: NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mary AGNES Murphy</b>			2a. DATE OF DEATH MONTH <b>07</b> DAY <b>24</b> YEAR <b>86</b> 2b. HOUR <b>11:40 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>05</b> DAY <b>24</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>County of Baltimore</b> MD.
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Delaware</b> 13b. COUNTY <b>New Castle</b> 13c. CITY OR TOWN <b>Wilmington</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1201 N. Harrison St., 19806</b>
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Walsh</b> LAST <b>Walsh</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Looney</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-05-8628</b>		17. INFORMANT ADDRESS <b>Sister Danielle Murphy 1201 N. Harrison</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY.IMMEDIATE CAUSE (a) **CARCINOMATOSIS, WITH EXTENSIVE NECK INVOLVEMENT** 1-2 WKS.

DUE TO, OR AS A CONSEQUENCE OF

(b) **POSSIBLE (L) BREAST CA. VS. TAIL OF PANCREAS CA. ? DENIED**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **NO**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <b>7-16</b> , 19 <b>86</b> , to <b>7-24</b> , 19 <b>86</b> , that (X) (we) last saw the deceased alive on <b>7-24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, check box.)			
22b. SIGNATURE <b>JAMES W. EAGAN, JR., M.D.</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>7/25/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES W. EAGAN, JR., M.D.</b>		22e. ADDRESS <b>7620 - YORK ROAD TOWSON MD 21204</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/28/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Wilmington</b> COUNTY <b>New Castle</b> STATE <b>DE</b>
24. FUNERAL DIRECTOR NAME <b>J. E. Lowell Lemmon</b> ADDRESS <b>10 W. Padonia Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1986</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Henderson</b>



00-13727

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 8 9 6 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Stanley Murphy, Sr.		2a. DATE OF DEATH MONTH DAY YEAR 7 24 86		2b. HOUR 1920 M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1 22 46		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital, INC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LONGSHOREMAN		12b. KIND OF BUSINESS OR INDUSTRY Shipping
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Anne Arundell	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 773 202nd Street
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin P. Clough		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy E. Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-44-1685		17. INFORMANT Patricia A. Murphy, same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

electromechanical disintegrator

DUE TO, OR AS A CONSEQUENCE OF

(b)

acute myocardial infarct

DUE TO, OR AS A CONSEQUENCE OF

(c)

Left main Coronary artery disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Colin		DEGREE			22c. DATE SIGNED 7/29/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Awalt		22e. ADDRESS 120 Sister Pierre Dr. Towson, Md. 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-28-86	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md.
24. FUNERAL DIRECTOR NAME Mc Cully F.H. 3204 Mountain Rd. Pasadena, Md.		25a. DATE REC'D. BY REGISTRAR JUL 29 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson - Pasadena

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people who have been involved in it.

2. The second part of the report is a detailed description of the methods used in the project. This includes a description of the equipment used, the procedures followed, and the data collected.

3. The third part of the report is a discussion of the results of the project. This includes a description of the data that was collected, a comparison of the results with the objectives of the project, and a discussion of the factors that may have influenced the results.

4. The fourth part of the report is a conclusion. This includes a summary of the findings of the project, a discussion of the implications of the findings, and a list of recommendations for future work.

5. The fifth part of the report is a list of references. This includes a list of the books, articles, and other sources that were used in the project.

6. The sixth part of the report is a list of appendices. This includes a list of the tables, figures, and other material that are included in the report.

7. The seventh part of the report is a list of acknowledgments. This includes a list of the people and organizations that have helped in the project.

8. The eighth part of the report is a list of footnotes. This includes a list of the notes that are included in the report.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="text-align: right;">86 18967</div> <div style="text-align: right;">REG. NO.</div>									
1. DECEASED NAME (TYPE OR PRINT) George Hasel Murray					2a. DATE OF DEATH MONTH DAY YEAR July 22, 1986			2b. HOUR 8:05 am	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Installer		12b. KIND OF BUSINESS OR INDUSTRY Vault Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 13217 Old Hanover Rd. 21136		
14. FATHER'S NAME John Murray			15. MOTHER'S MAIDEN NAME Laura Tinkler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 216-10-0314		17. INFORMANT ADDRESS Clara M. Murray 13217 Old Hanover Rd. Reisterstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARDS &amp; Pulm Effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic metastasis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>① DM &amp; MI ② Diabetes Keto acidosis ③ Massive Ascites</u>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:05 P.M. 7 22 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/30 19 86 to 7/22 19 86, that (I) (we) lost saw the deceased alive on 7/22/86 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Randallstown Baltimore County Gen. Hospital, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.		
24. FUNERAL DIRECTOR <i>[Signature]</i>			25a. ADDRESS Owings Mills, Md.			25b. DATE REC'D BY REGISTRAR JUL 24 1986			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>NICHOLAS J. NARGI</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 23, 1986</b>		2b. HOUR <b>7<sup>20</sup> A.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 20 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Designer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coat Co.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6910 Lacklan Circle 21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>30 Alexander M. Nargi</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-09-0312</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret Nargi Same as 13 e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Obstructive Pulmonary Disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Beatriz P. Dizon</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>7/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Beatriz P. Dizon M.D.</b>				22e. ADDRESS <b>St. Joseph Hospital - Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>7/24/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>Ruck Towson Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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1-9-68

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

1-9-68

Memorandum

Date

1-9-68

Re: [illegible]

x

Cost Co.

Resident

2410 Jackson Circle 2123

x

Witness

to

Party

and

Alexander H.

One as is e

Pro. [illegible]

212-9-0312

to



St. Joseph Hospital - Towson, Md. 21204

Central P. [illegible]

Latvia Cemetery, Baltimore, Md.

7/24/67

Latvia Cemetery, Inc. 1000 [illegible]

00-12752

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 18769

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary S. Nazay</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 14, 1986</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>December 23, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chapel Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Randallstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Duralja</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Kostelac</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Frank J. Nazay, Jr. Randallstown, MD 21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular arrest 20 to</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable coronary Artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Even cardiac arrest - possible New M.I.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arterio-sclerotic Cardio-vascular disease with previous myocardial infarction</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11/1986</b> to <b>7/14/1986</b> , that (I) (we) lost saw the deceased alive on <b>7/12/1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R.M. Shan M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/15/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAN</b>		22e. ADDRESS <b>10706 Reisterstown Rd. Reisterstown, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>7/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harrisburg, Dauphin Pennsylvania</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, INC. 8728 Liberty Road Randallstown, MD 21133-4784</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1986</b>			
25b. REGISTRAR'S SIGNATURE					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG.

86 18970

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANTOINETTE K. NEAL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 28, 1986</b>			2b. HOUR P M <b>11:30 P</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 19, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>RELAY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1707 ARLINGTON AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>RELAY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>1707 ARLINGTON AVENUE 21227</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>STEPHEN KMIETCIK</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>KATHLEEN NEAL 1707 ARLINGTON AVENUE 21227</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident to Myocardium</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aphasia?</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>84</u> to <u>7/28</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/28/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John C. Healy</i>			DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JOHN C. HEALY M.D.</b>			22e. ADDRESS <b>1311 FRANCIS AVENUE 21227</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>08/1/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DORSEY HOWARD MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>AMBROSE FUNERAL HOME</b>			25a. DATE RECEIVED BY REGISTRAR <b>JUL 31 1986</b> 25b. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 should be retained by the funeral director, page 4 may be retained by the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 8618971		2a DATE OF DEATH MONTH 6 DAY 28 YEAR 86		2b HOUR 7:20 PM			
1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Neavitt</b>		FIRST <b>ELIZABETH</b> MIDDLE <b>T.</b> LAST <b>NEAVITT</b>		3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>April</b> DAY <b>13</b> YEAR <b>1905</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>			
13a STATE <b>MD</b>		13b COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Md. 21228</b> <b>1222 Canberwell Rd. Catonsville</b>	
14 FATHER'S NAME FIRST <b>Harwell</b> MIDDLE LAST <b>Thomas</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Leona</b> MIDDLE LAST <b>Fear</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>219-50-3162</b>		17 INFORMANT ADDRESS <b>Nancy E Wolf</b> <b>1222 Canberwell Road</b> <b>Catonsville, MD. 21228</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA - Vascular Malformation</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA - R. Meningeal</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>8-2-74</b> , 19 <b>6288</b> , to <b>6-28-86</b> , 19 <b>86</b> , that (I) (we) last saw the deceased on <b>6-28-86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, indicate that view the body after death.)									
22b SIGNATURE <b>George E. Pngol</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>6/28/86</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE E. PNGOL</b>		22e ADDRESS <b>3350 Woodlawn</b> <b>Baltimore, MD.</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>7/1/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn MD.</b>			
24 FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>				25a DATE REC'D. BY REGISTRAR <b>JUN 30 1986</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			

100% COTTON TIBER

WINTER

WINTER



00-13454

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Celeste Louise Netzer			2a. DATE OF DEATH MONTH DAY YEAR 07-23/86			2b. HOUR 1:20 A <sub>M</sub>				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 11 28 09		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10 CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Winters Lane Village Oakes Apt 21228	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Wolfe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celeste L. Gregory							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-22-1702-A		17. INFORMANT 604 Oakhill Rd. Catonsville, MD Mrs. Esther Weinhardt 21228					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse metastatic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-9</u> , 19 <u>85</u> , to <u>7-23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Harold B. Bob</u> MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob, MD			22e. ADDRESS 7220 Park Heights Avenue							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07/25/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City MD			
24 FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home, Catonsville, MD					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JUL 25 1986 Julia Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

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Handwritten notes and signatures along the right margin.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 1 8 9 7 3

1- FOR  
STATE  
REGISTRAR

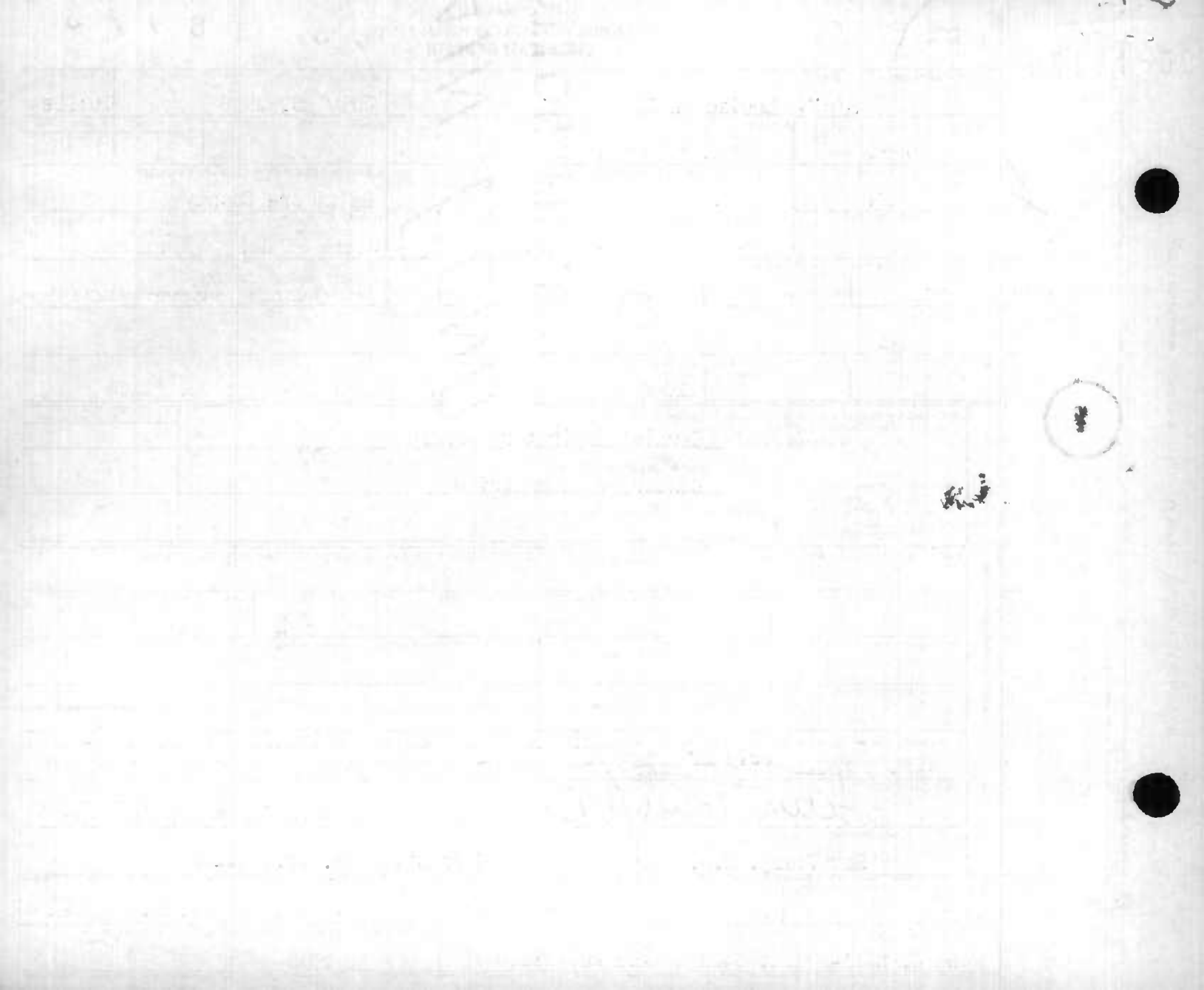
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marion Louise NEVIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 29, 1986</b>			2b. HOUR <b>10:00a M</b>	
3. SEX <b>Fem.</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 15 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State of Md.</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>							
13a. STATE <b>Md.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>2720 Huntington Ave. 21211</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Disney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marion Tawney</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-09-6109</b>		17. INFORMANT ADDRESS <b>Daniel A. Nevin 125 Orange Ct. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of Endometrium</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: _____							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (H) (this hospital) attended the deceased from <b>July 28</b> , 19 <b>86</b> , to <b>July 29</b> , 19 <b>86</b> , that (H) (we) last saw the deceased alive on <b>July 29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sam Toueg</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>07/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sam Toueg, M.D.</b>				22e. ADDRESS <b>9000 Franklin Sq. Dr., 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc. 6415 Belair Rd. 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1986</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (anatomy, page 1) and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



0-13387

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 18974

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES R NICHOLSON, SR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 16, 1986</b>		2b. HOUR 1:34 PM	
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 5, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Postal Service</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Kentucky</b>		13b. COUNTY <b>Fayette</b>	13c. CITY OR TOWN <b>Lexington</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Nicholson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Siler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>404-60-1465</b>		17. INFORMANT ADDRESS <b>Corwyn Nicholson - same as #13e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Acute MYOCARDIAL INFARCTION**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**24 hours**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**PARKINSON'S DISEASE**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>7/15</b> 19 <b>86</b> to <b>7/16</b> 19 <b>86</b> , that (2) (we) last saw the deceased alive on <b>7/15</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (3) we did not view the body after death.			
22b. SIGNATURE <b>Benny Discepis</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/16/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benny Discepis</b>	22e. ADDRESS <b>7600 Old Rd. Towson MD.</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 26, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Englewood Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hazard Kentucky</b>
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24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>	ADDRESS <b>1050 York Rd.</b>	25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1986</b>	25b. REGISTRAR'S SIGNATURE <i>John David Anderson</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, any completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

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Handwritten text, possibly "12-12-64" or similar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELEANOR BRIDGET NOLL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 29 86</b>			2b. HOUR <b>3<sup>10</sup> P M</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 28 10</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian N.H. - Catonsville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>946 Paladi Drive 21227</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Burns</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Schramm</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-22-9933</b>		17. INFORMANT ADDRESS <b>Richard Noll 10505 Tolling Clock Way 21044</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of lung &amp; metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastasis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> , 19 <b>86</b> , to <b>7/24</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Spencer H. Shaw</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/24/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Spencer H. Shaw</b>		22e. ADDRESS <b>5805 Edmonson Ave. 21227</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc 4107 Wilkens Ave.</b>				ADDRESS <b>21229</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

20% COTTON 20%

John H. Brown  
The Cotton Co. Inc.  
1/1/12

00-14216

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 18976

1. DECEASED NAME (TYPE OR PRINT) <b>MARCOS</b>		FIRST <b>MARCOS</b> MIDDLE <b>NOVODVORIZ</b> LAST <b>NOVODVORIZ</b>		2a. DATE OF DEATH MONTH <b>17</b> DAY <b>29</b> YEAR <b>86</b>		2b. HOUR <b>5:30 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>24</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Argentina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CABINET MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WOOD</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>MAURICIO</b> MIDDLE <b>NOVODVORIZ</b> LAST <b>NOVODVORIZ</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>GELMAN</b> LAST <b>GELMAN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>212 56 3816</b>		17. INFORMANT <b>MRS. SARA NOVODVORIZ</b> <b>194 PITTSTON CIR. OWINGS MILLS, MD 21117</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>Cancer of Pancreas &amp; Intestinal Obstruction</b>							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that this hospital attended the deceased from <b>7/14</b> 19 <b>86</b> to <b>7/29</b> 19 <b>86</b> , that <input checked="" type="checkbox"/> the deceased <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>Robert J. Moss</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/29/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Moss</b>		22e. ADDRESS <b>Baltimore County Gen Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 30, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1986</b>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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00-12579

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH</b>		FIRST MIDDLE LAST <b>OCHERT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 10, 1986</b>		2b. HOUR <b>11 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 17, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>OLD COURT NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. STREET ADDRESS / ZIP CODE <b>5412 OLD COURT RD. #21133</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SOLOMON DEARING</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-10-5604</b>	
17. INFORMANT <b>LLOYD R. HELT, JR. ATTY.</b>		17. ADDRESS <b>7600 MAIN ST. SYKESVILLE, MD 21784</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Arteriosclerotic Heart Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> to <b>7/10</b> 19 <b>86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (if (we) did not see the body after death, so state).		22b. SIGNATURE <b>Dr. Morton Sellin</b>		22c. DATE SIGNED <b>7/10/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MORTON SELLIN</b>		22e. ADDRESS <b>5310 OLD COURT RD. RAND. MD. 21133</b>		23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>JULY 11, 1986</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW ORTHODOX MEM. S.N.C.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>		25c. ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>		25d. DATE REC'D. BY REGISTRAR <b>JUL 16 1986</b>		25e. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

3541 NOTION 202

Handwritten notes, possibly including "C. ...", "C. ...", and "C. ...".

Handwritten notes, possibly including "C. ...", "C. ...", and "C. ...".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (boxed).

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. N

86 18978

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>FRANK Charles Ochlech</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>7 8 86</u>			2b. HOUR <u>8<sup>30</sup> A M</u>			
3. SEX <u>Male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Jan. 6, 1933</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>53</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balto. Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County MD.</u>			
10. CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Stella Maris Hospice</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Masonry Teacher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. School System</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Joppa</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>434 Haslett Rd. 21085</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Frank J. Ochlech</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary A. Kapela</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>no</u>				16b. SOCIAL SECURITY NO. <u>216-28-0827</u>		17. INFORMANT ADDRESS <u>Mrs. Shirley K. Ochlech, Joppa, Md. 21085</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oblioblastoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>WITH METASTATIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> , 19 <u>86</u> , to <u>7/8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Eddie Nakhuda, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7-8-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>Stella Maris Hospice</u> <u>2300 Dulany Valley Rd. - Towson, MD 21204</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>7-10-1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Luth. Ch. Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Joppa Harford Md.</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</u>					25a. DATE REC'D. BY REGISTRAR <u>JUL 11 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Randall</u>		

BP \_\_\_\_\_

87981

0041212

SECTION 100  
DRAFT

(1)

00-12118

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

18979

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCIS O'MEARA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7/9/86</b>		2b. HOUR MIN. <b>10:20 A</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5910 Bellona Ave., 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael O'Meara</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Toal</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217 54 9549</b>		17. INFORMANT ADDRESS <b>Fr. Joseph O'Meara, Balto., MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiration 2° recurrent</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiovascular accidents.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (this hospital) attended the deceased from <b>10-9</b> , 19 <b>80</b> , to <b>7-9</b> , 19 <b>86</b> , that (I) (we) lost sight of the deceased alive on <b>6-30</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (we) (we) saw the body after death.									
22b. SIGNATURE <b>Harold P. Bobbitt MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-10-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold P. Bobbitt</b>						22e. ADDRESS <b>7220 Park Heights 21208</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/11/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>		
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>						25a. DATE REC'D BY REGISTRAR <b>JUL 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rondeau</b>	
4905 York Road Balto., MD 21212									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical certificate is valid without a death certificate.



00-12532

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

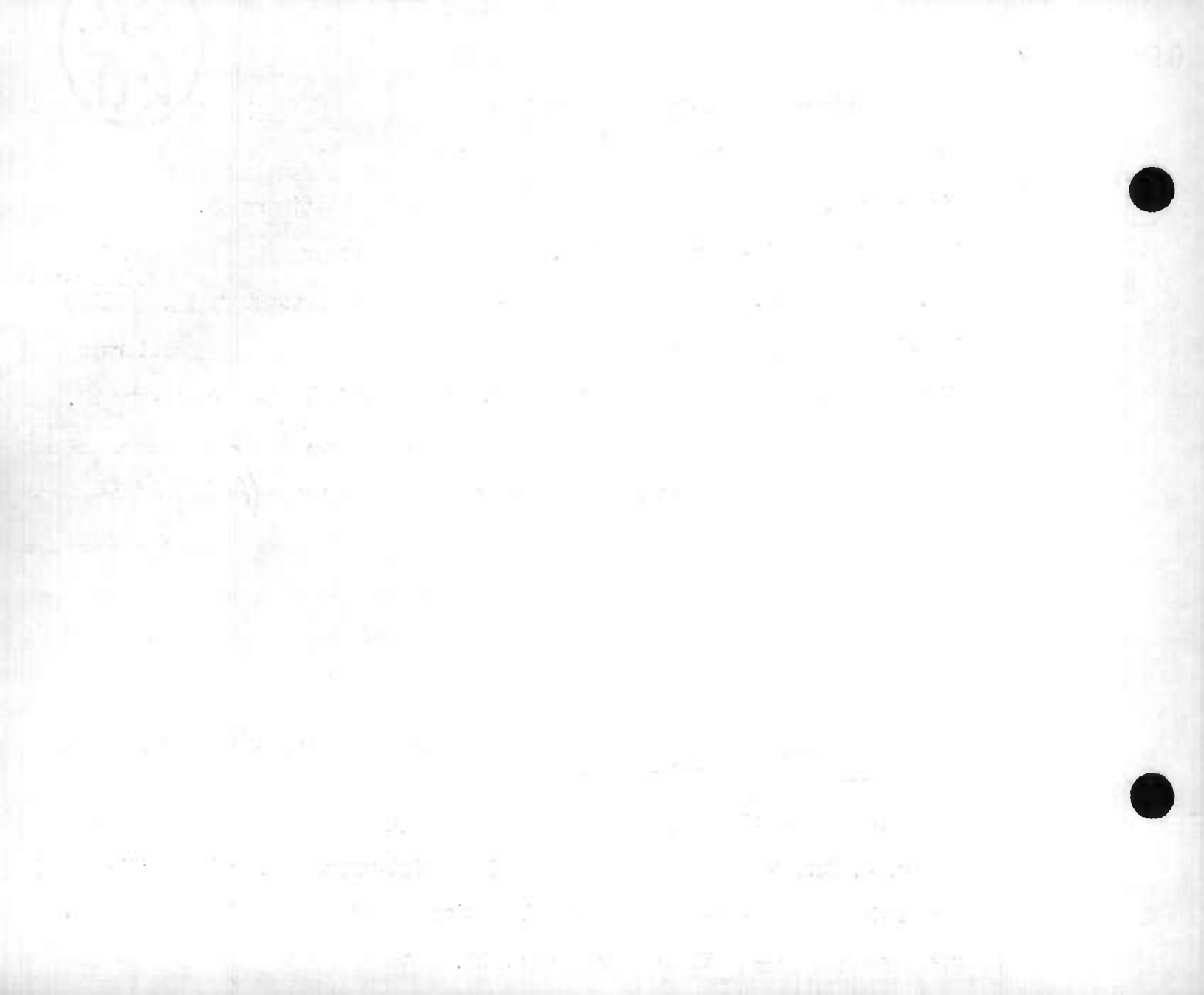
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Oliver Adolph Ortinau			2a. DATE OF DEATH MONTH DAY YEAR 7 13 1986			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 28 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, Ill.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21-A Brookebury Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21-A Brookebury Rd. 21136		
14. FATHER'S NAME FIRST MIDDLE LAST Michael John Ortinau				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Westerman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Vivian Ortinau 21-A Brookebury Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD &amp; vascular insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>19 80</u> to <u>April</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>N. Turkman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-14-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Turkman				22e. ADDRESS 10706 Reisterstown Rd. Owings Mills 21117							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 7-14-86		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation			23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home						25a. DATE REC'D. BY REGISTRAR JUL 15 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



00-12449

Film G617 Item 23c, 23d

1- FOR  
STATE  
REGISTRAR

7/10/86 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MYRTLE E. OWINGS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 12, 1986</b>		2b. HOUR M								
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 11, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD							
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presbyterian Home of Maryland</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3502 Mayfair Rd. 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William A. Herring</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma V. Kennard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-07-6129</b>		17. INFORMANT ADDRESS <b>Presbyterian Home of Maryland, Towson, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTE</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>- PARKINSON'S DISEASE</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <b>5-10-1986</b> to <b>July 12, 1986</b> , that (I) (we) lost saw the deceased alive on <b>July 9, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Sidney J. Venable, Jr. M.D.</b> DEGREE <b>MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-14-86</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sidney J. Venable, Jr. M.D.</b>						22e. ADDRESS <b>7215 York Rd. Baltimore, Md. 21212</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 15, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION <b>Baltimore City Baltimore Co., Md.</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, when any injury, or other traumatic event, the medical examiner must be notified at once.



00-12501

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carolyn Helen Rodgers Paulsen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 14 1986</b>			2b. HOUR <b>4 A M</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 29 1944</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>42</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Sparks</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 Hunts Farm Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bank Executive</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Sparks</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10 Hunts Farm Court, 21152</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John William Rodgers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola Helen Telmanski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17 INFORMANT ADDRESS <b>E. Michael Paulsen, 10 Hunts Farm Ct., 21152</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF b) <b>CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF c) <b></b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> , 19 <b>85</b> , to <b>7/14</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>4/9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Charles O'Donovan, III M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/14/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles O'Donovan, III M.D.</b>				22e. ADDRESS <b>9 E. Chase Street, Baltimore, Md.</b>						

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/16/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Balto. Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	
24 FUNERAL DIRECTOR ADDRESS <b>Martin D. Lawson, 10 W. Padonia Rd. 21093</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John William Smith  
1010 1st St. N.E.  
Washington, D.C. 20002  
Phone: 202-555-1234  
Date: 10/10/73  
To: Mr. J. Edgar Hoover  
Subject: [Illegible]

[Illegible text block containing several lines of mirrored or bleed-through text]

08-14424

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Clarence William PEARCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1986</b>		2b. HOUR <b>9:20p M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 30 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shop Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Hwy. Dept.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>21128</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Pearce</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Obitz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-05-4749</b>		17. INFORMANT ADDRESS <b>Mrs. Grace Pearce 9229 Cowenton Ave. 21128</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardio-pulmonary Disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **End Stage Chronic Obstructive Pulmonary  
Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Coronary Artery Disease, Diabetes Mellitus, Hypertension**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 25, 1986</b> to <b>July 26, 1986</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>July 26, 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <b>Michael Leonidov MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-26-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Leonidov, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-30-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lescage Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1986</b>			
				25b. REGISTRAR'S SIGNATURE <b>John Benson-Radner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 4 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



15-15  
0-72854

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST <b>Bertha L. Pensmith</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7-12-86</b>	
3. SEX <b>Female</b>		2b. HOUR <b>705 p.m.</b>	
4. RACE <b>White</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
5. DATE OF BIRTH MONTH DAY YEAR <b>7 17 03</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nurs. Home</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	
13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Langville</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Maddox</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-8711</b>	
17. INFORMANT ADDRESS <b>Ms. Emma Kaufman 4 N. Rolling Rd. Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>END STAGE - OVARIAN CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INSTANTANEOUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADULT</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>			
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>8/30</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>8/30</b> , 19 <b>86</b> , to <b>7/12</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <b>Julia H. Snow M.D.</b> DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/12/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julia H. Snow M.D.</b>		22e. ADDRESS <b>5800 Edmonstone Ave. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>7-12-86</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 21 1986</b>	
ADDRESS <b>Balto., Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is the duty of the physician to report the same to the State Dept. of Health and Mental Hygiene.



BRIDGE  
MILWAUKEE  
NOTES 2000

*[Faint, mostly illegible handwritten text and markings, possibly including a signature and date.]*

6  
0-13534



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 86 18985							
1. DECEASED NAME (TYPE OR PRINT) George O Pfann				2a. DATE OF DEATH MONTH DAY YEAR July 16, 1986		2b. HOUR 8:39p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 9 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher		12b. KIND OF BUSINESS OR INDUSTRY Batten Food Mkt	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 Chesley Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Otto Pfann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-07-0639		17. INFORMANT ADDRESS Mrs. Mary McCarl Perry Hall, Md. 9900 Marilynn Rd. 21128					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from July 16, 1986, to July 16, 1986, that (we) last saw the deceased alive on July 16, 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/16/86			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) T.E. Harrison, M.D.				23b. ADDRESS 9000 Franklin Square Drive 21237					
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 7-19-86		23e. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR Lassus # 7401				25a. DATE REC'D. BY REGISTRAR JUL 21 1986		25b. REGISTRAR'S SIGNATURE 			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 18986

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH                                       |  | 2b. DATE OF ESTI- MATED  |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  |
| ANTHONY ALLAN PHELPS III   |  | Male  |  | White  |  | Jan. 13, 1958   |  | 28 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. CITY OR TOWN OF DEATH   |  |
| Baltimore, Md.   |  | USA   |  |  |  | Baltimore County  |  | Catonsville   |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE  |  | 13b. COUNTY   |  |
| Simpkins Industries Plant  |  | Fork Lift Operator  |  | Paper Mill   |  | Maryland  |  | Baltimore   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                      |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| Anthony A. Phelps  |  | Lillian Davies  |  | No   |  | 218 74 3521   |  | Carol Phelps, Wife  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | 21a. EXTERNAL CAUSE WAS   |  |
| PART I DEATH WAS CAUSED BY:  |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |  |   |  |  |  |   |  | 21b. TIME OF INJURY   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  | HOUR A.M. MONTH DAY YEAR  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                  |  |   |  |  |  |   |  | P.M. 7-30-86 19   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| (c)  |  |   |  |  |  |   |  | subject fell into filler pulper   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  |   |  |  |  |   |  | 21d. INJURY OCCURRED  |  |
|  |  |   |  |  |  |   |  | WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
|  |  |   |  |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |
|  |  |   |  |  |  |   |  | industry plant  |  |
|  |  |   |  |  |  |   |  | 21f. LOCATION   |  |
|  |  |   |  |  |  |   |  | Simpkins Industries Plant Catonsville, Md.  |  |
|  |  |   |  |  |  |   |  | 22a. I certify that I took charge of the remains described above, held on   |  |
|  |  |   |  |  |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  |
|  |  |   |  |  |  |   |  | death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |
|  |  |   |  |  |  |   |  | ACTUAL SIGNATURE  |  |
|  |  |   |  |  |  |   |  | Margarita A. Korell, M.D.   |  |
|  |  |   |  |  |  |   |  | TITLE (SPECIFY)   |  |
|  |  |   |  |  |  |   |  | Assistant   |  |
|  |  |   |  |  |  |   |  | MEDICAL EXAMINER  |  |
|  |  |   |  |  |  |   |  | 7-30-86   |  |
|  |  |   |  |  |  |   |  | SIGNED  |  |
|  |  |   |  |  |  |   |  | EXAMINER'S NAME (TYPE OR PRINT)   |  |
|  |  |   |  |  |  |   |  | 111 Penn Street   |  |
|  |  |   |  |  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL   |  |
|  |  |   |  |  |  |   |  | 23b. DATE   |  |
|  |  |   |  |  |  |   |  | 8/1/86  |  |
|  |  |   |  |  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
|  |  |   |  |  |  |   |  | Gardens of Faith  |  |
|  |  |   |  |  |  |   |  | 23d. LOCATION   |  |
|  |  |   |  |  |  |   |  | Baltimore Co., Md.  |  |
|  |  |   |  |  |  |   |  | 24. FUNERAL DIRECTOR  |  |
|  |  |   |  |  |  |   |  | 25. DATE RECD. BY REGISTRAR   |  |
|  |  |   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |  |  |   |  | JUL 31 1986   |  |
|  |  |   |  |  |  |   |  | 1407 Old Eastern Ave  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 18987  
REG. NO.

|   |  |  |   |                                |  |
|---|--|--|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | 9:50A. M                       |  |
| JOHN ANDER PHILLIPS   |  | 7 14 86  |   |                                |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                |  |
| MALE  | WHITE  | MONTH DAY YEAR   | 93  | MONTHS DAYS HOURS MIN.         |  |
|   |  | 4 25 93  |   |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                |  |
| W. Virginia   | U.S.A.   |  | Baltimore County MD.  |                                |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                |  |
| Woodlawn  | 2000 Hillcrest Road  | Machine Operator   | Factory   |                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |                                |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE |  |
| Maryland  | Baltimore  | Woodlawn   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 2000 Hillcrest Road 21207      |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  | ADDRESS   |                                |  |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |  |   |                                |  |
| Moses Phillips  | Florida Sheets   |  |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS  |   |                                |  |
| NO  | 233-10-9028  | Arietta Galford 2000 Hillcrest Rd. 21207   |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>  |  |  |   |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD, pernicious anemia</u>   |  |  |   |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |                                |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                |  |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |                                |  |
|   |  |  |   |                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>52</u> , to <u>7/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |                                |  |
| 22b. SIGNATURE  | DEGREE   |  |   | 22c. DATE SIGNED               |  |
|   |  |  |   | 7/14/86                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |  |   |                                |  |
| John Shaw   | 5800 Edmondson Avenue  |  |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                |  |
| Burial  | 7/17/86  | Good Shepherd Cemetery   | Ellicott City Howard Md.  |                                |  |
| 24. FUNERAL DIRECTOR NAME   | 25a. DATE REC'D. BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE   |   |                                |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229  | JUL 16 1986  |  |   |                                |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 REG. NO. 18988

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                      |
|--|--|---|---|--|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANK J Phipps</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>2</b> YEAR <b>1986</b> |  | 2b. HOUR<br><b>M</b> |
| 1. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>9</b> YEAR <b>24</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS                                     |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. C</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                      |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hosp</b>           |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel</b>     |                      |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem</b>  |  | 13a. STATE<br><b>Md</b>   |   | 13b. COUNTY<br><b>BALTO</b>  |                      |
| 13c. CITY OR TOWN<br><b>Randallstown</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2826 Arlene Circle 21207</b>                    |                      |
| 14. FATHER'S NAME (FIRST)<br><b>Dwiley</b>   |  | 15. MOTHER'S MAIDEN NAME (FIRST)<br><b>Laura</b>  |   | 15. MOTHER'S MAIDEN NAME (MIDDLE)<br><b>Edmonds</b>                                  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>239-28-0281</b>  |   | 17. INFORMANT ADDRESS<br><b>Naomi Phipps 2826 Arlene circle</b>                      |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>widespread Pulmonary adenoCa.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>AdenoCa of Lung, Pleura, liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |                      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR (A.M. MONTH DAY YEAR)<br><b>615 A.M. 7 2 1986</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |                      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                      |
| 22. I certify that (I) (this hospital) attended the deceased from <b>6/25/1986</b> to <b>7/2/1986</b> that (I) (we) last saw the deceased alive on <b>1045 PM 7/2/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |                      |
| 22b. SIGNATURE <b>m. mark</b> DEGREE <b>MD</b>   |  |   |   | 22c. DATE SIGNED   |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |   | 22e. ADDRESS   |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/6/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Phipps Family Cemetery</b>                  |                      |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Littleton</b>  |  | COUNTY<br><b>N.C.</b>   |   | STATE  |                      |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March Funeral Home West 4300 Wabash Avenue</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1986</b>                                   |                      |
| ADDRESS  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |                      |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, a medical examiner must be notified and a medical examination must be made.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | HOURS MIN.   |  |
| FIRST MIDDLE LAST   |  | 07 13 86   |  | 3:35 P M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| Female  |  | White  |  | MONTH DAY YEAR   |  |
|   |  |  |  | March 1, 1903  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Maryland  |  | USA  |  | 83   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| TOWSON  |  | GBMC 6701 N. CHARLES STREET  |  | BALTIMORE COUNTY MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Homemaker   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland  |  | Baltimore  |  | Towson   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | 205 E. Joppa Rd. 21204   |  |
| George MacGill  |  | Margaret Kohlhofer   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| No  |  | 215-56-4833  |  | 300 Old Trail  |  |
|   |  |  |  | George W.H. Pierson, II Baltimore, Md. 21212                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) RUPTURE OF ABDOMINAL AORTIC ANEURYSM  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1986, to 7/13, 1986, that (I) (we) lost saw the deceased alive on 7/13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| L. Kauffman M.D.  |  |  |  | 7/13/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| DR L. KAUFFMAN  |  | GBMC 6701 N. CHARLES STREET TOWSON MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | July 16, 1986  |  | Loudon Park  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| 6500 York Rd. Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  | JUL 15 1986  |  | John Harrison  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | 23e. DATE REC'D. BY REGISTRAR  |  | 23f. REGISTRAR'S SIGNATURE   |  |
| Baltimore City Maryland   |  |  |  |  |  |

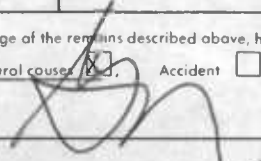
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0-13863

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                            |  |   |   |  |  |   |  | 1 8 9 9 0<br>REG. NO.  |   |
|--|--|----------------------------|--|---|---|--|--|---|--|--|---|
| 1- STATE REGISTRAR   |  |                            |  |   |   |  |  |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Angelo I. Promutico, JR.</b>  |  |                            |  |   |   |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7/ 23/ 86</b> 2b. HOUR <b>3:31 P M</b> |   |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Cauc.</b>       |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 18, 1924</b>        |   | 6. AGE (IN YEARS) LAST BIRTHDAY <b>62 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS <b>- -</b>                                   |  | IF UNDER 24 HRS. HOURS MIN <b>- -</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                            | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>               |  |   |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |  |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b> |   |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Ind.</b> |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                            |  |   |   |  |  |   |  |  |   |
| 13a. STATE <b>Maryland</b>   |  | 13b. CITY <b>Baltimore</b> |  | 13c. CITY OR TOWN <b>Woodlawn</b>                           |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>6615 Richardson Road, 21207</b>                  |  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Angelo I. Promutico, Sr.</b>  |  |                            |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence S. Jennings</b>   |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                            |  | 16b. SOCIAL SECURITY NO. <b>219-16-8464</b>                 |   | 17. INFORMANT ADDRESS <b>Elsie E. Promutico, 6615 Richardson Rd. 21207</b>   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                            |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                            |  |   |   |  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                            |  |   |   |  |  |   |  |  |   |
| ACTUAL SIGNATURE  M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |                            |  |   |   |  |  |   |  | DATE SIGNED <b>7/24/86</b>   |   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b> ADDRESS <b>111 Penn St.</b>   |  |                            |  |   |   |  |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                            | 23b. DATE <b>7/28/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cem.</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b> |  |  |   |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>JAMES N. KOTSIS F.H., 6411 Windsor Mill Rd.</b>   |  |                            |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |

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JAMES H. ROYCE, JR., 6111 Windsor Mill Rd.

Partial 7/28/86 Mont Co. Treasurer Gen. Baltimore City, Maryland

No 1/A 219-16-1111 Elsie R. Brownlee, 6015 Richardson Rd. 21207  
Angelo I. Brownlee, Jr. Florence R. Jennings  
Maryland Baltimore Woodlawn x 6015 Richardson Road, 21207  
Male 7.2.4. x  
Cauc. Feb. 18, 1924 62  
I. 1.

Steel Inc.

0-12128

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 5618991   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William A. QUINN  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 10, 1986   |  | 2b. HOUR<br>2:00a M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>08 12 01   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OFFICER                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BANK  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>ROSEDALE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8013 OLD PHILADELPHIA RD. 21237  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>----- QUINN   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>-----   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220010977  |  | 17. INFORMANT ADDRESS<br>FRIDA QUINN 8013 OLD PHILADELPHIA RD.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Prostate Metastasis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Colon and Duodenal involvement<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY STATE   |  |
| 22a. I certify that (he) (this hospital) attended the deceased from June 30, 1986, to July 10, 1986, that (we) lost saw the deceased alive on July 10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Lam Young  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>07/10/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAM TOUNG MD  |  |  |  | 22e. ADDRESS<br>9000 Franklin Sq. Dr., 21237  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>07/12/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |  | 23d. LOCATION CITY OR TOWN<br>BALTO.  |  | COUNTY STATE<br>BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Jeford 1211 Chesapeake Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

D-15158

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Name of Subject                       |  | 2. Date of Birth                         |  | 3. Sex                                   |  |
| 4. Race                                  |  | 5. Height                                |  | 6. Weight                                |  |
| 7. Eyes                                  |  | 8. Hair                                  |  | 9. Complexion                            |  |
| 10. Place of Birth                       |  | 11. Date of Entry into Country           |  | 12. Date of Departure from Country       |  |
| 13. Date of Arrival at Destination       |  | 14. Date of Departure from Destination   |  | 15. Date of Return to Country of Origin  |  |
| 16. Date of Return to Country of Origin  |  | 17. Date of Return to Country of Origin  |  | 18. Date of Return to Country of Origin  |  |
| 19. Date of Return to Country of Origin  |  | 20. Date of Return to Country of Origin  |  | 21. Date of Return to Country of Origin  |  |
| 22. Date of Return to Country of Origin  |  | 23. Date of Return to Country of Origin  |  | 24. Date of Return to Country of Origin  |  |
| 25. Date of Return to Country of Origin  |  | 26. Date of Return to Country of Origin  |  | 27. Date of Return to Country of Origin  |  |
| 28. Date of Return to Country of Origin  |  | 29. Date of Return to Country of Origin  |  | 30. Date of Return to Country of Origin  |  |
| 31. Date of Return to Country of Origin  |  | 32. Date of Return to Country of Origin  |  | 33. Date of Return to Country of Origin  |  |
| 34. Date of Return to Country of Origin  |  | 35. Date of Return to Country of Origin  |  | 36. Date of Return to Country of Origin  |  |
| 37. Date of Return to Country of Origin  |  | 38. Date of Return to Country of Origin  |  | 39. Date of Return to Country of Origin  |  |
| 40. Date of Return to Country of Origin  |  | 41. Date of Return to Country of Origin  |  | 42. Date of Return to Country of Origin  |  |
| 43. Date of Return to Country of Origin  |  | 44. Date of Return to Country of Origin  |  | 45. Date of Return to Country of Origin  |  |
| 46. Date of Return to Country of Origin  |  | 47. Date of Return to Country of Origin  |  | 48. Date of Return to Country of Origin  |  |
| 49. Date of Return to Country of Origin  |  | 50. Date of Return to Country of Origin  |  | 51. Date of Return to Country of Origin  |  |
| 52. Date of Return to Country of Origin  |  | 53. Date of Return to Country of Origin  |  | 54. Date of Return to Country of Origin  |  |
| 55. Date of Return to Country of Origin  |  | 56. Date of Return to Country of Origin  |  | 57. Date of Return to Country of Origin  |  |
| 58. Date of Return to Country of Origin  |  | 59. Date of Return to Country of Origin  |  | 60. Date of Return to Country of Origin  |  |
| 61. Date of Return to Country of Origin  |  | 62. Date of Return to Country of Origin  |  | 63. Date of Return to Country of Origin  |  |
| 64. Date of Return to Country of Origin  |  | 65. Date of Return to Country of Origin  |  | 66. Date of Return to Country of Origin  |  |
| 67. Date of Return to Country of Origin  |  | 68. Date of Return to Country of Origin  |  | 69. Date of Return to Country of Origin  |  |
| 70. Date of Return to Country of Origin  |  | 71. Date of Return to Country of Origin  |  | 72. Date of Return to Country of Origin  |  |
| 73. Date of Return to Country of Origin  |  | 74. Date of Return to Country of Origin  |  | 75. Date of Return to Country of Origin  |  |
| 76. Date of Return to Country of Origin  |  | 77. Date of Return to Country of Origin  |  | 78. Date of Return to Country of Origin  |  |
| 79. Date of Return to Country of Origin  |  | 80. Date of Return to Country of Origin  |  | 81. Date of Return to Country of Origin  |  |
| 82. Date of Return to Country of Origin  |  | 83. Date of Return to Country of Origin  |  | 84. Date of Return to Country of Origin  |  |
| 85. Date of Return to Country of Origin  |  | 86. Date of Return to Country of Origin  |  | 87. Date of Return to Country of Origin  |  |
| 88. Date of Return to Country of Origin  |  | 89. Date of Return to Country of Origin  |  | 90. Date of Return to Country of Origin  |  |
| 91. Date of Return to Country of Origin  |  | 92. Date of Return to Country of Origin  |  | 93. Date of Return to Country of Origin  |  |
| 94. Date of Return to Country of Origin  |  | 95. Date of Return to Country of Origin  |  | 96. Date of Return to Country of Origin  |  |
| 97. Date of Return to Country of Origin  |  | 98. Date of Return to Country of Origin  |  | 99. Date of Return to Country of Origin  |  |
| 100. Date of Return to Country of Origin |  | 101. Date of Return to Country of Origin |  | 102. Date of Return to Country of Origin |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 thru 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |   | 86  | 18992 |
|---|--|--|--|---|--|--|--|--|---|---|-------|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |   | REG. NO.  |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>ELSIE   | MIDDLE<br>K.  | LAST<br>RAINEY                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7/29/86                                     |  |  | 2b. HOUR<br>8:47 P M  |   |       |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/13/14   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS<br>HOURS MIN.   |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD                           |  |  |   |   |       |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Binder |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Printing Co.  |   |   |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>md.   |  |  |  |   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Cockeysville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank N. Denton   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Millie Wiedner   |  |  |  | 16. SOCIAL SECURITY NO.<br>325322568   |   |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Reeda G. Zebec -13 F Windy Cliff Pl. 21030  |  |  |  | 17. ADDRESS  |   |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RIGHT PNEUMORECTOMY</u>  |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><u>CARCINOMA (R) LUNG</u>  |  |  |  |   |  |  |  |  |   |   |       |
| 19a. DATE OF OPERATION<br>7/16/86   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CARCINOMA (R) LUNG |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |  |   |   |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |   |   |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>86</u> , to <u>7/29</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>7/29/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |   |   |       |
| 22b. SIGNATURE<br><u>Auram Karas</u>  |  |  |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>7/29/86   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AURAM KARAS  |  |  |  | 22e. ADDRESS<br>1900 EAST NORTON PKW, 21239   |  |  |  |  |   |   |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>8-2-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto., Md.  |   |   |       |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |  |  | 25a. DATE RECD. BY REGISTRAR<br>JUL 31 1986   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |   |   |       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-13010

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DOROTHY L. RAMMING                         |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 18 86 |   |  | 2b. HOUR<br>4:18A.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 15, 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                      |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br>Arbutus   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4601 College Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Cornell Chemical Co.  |  | 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Arbutus   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 13e. STREET ADDRESS / ZIP CODE<br>4601 College Avenue 21227  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Esmer   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Giller                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>219-05-8342  |  | 17. INFORMANT<br>ADDRESS<br>Albert A. Romoser 757 223 St. 21122   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinomatous

DUE TO, OR AS A CONSEQUENCE OF

(b)

Carcinoma of Head of Pancreas

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

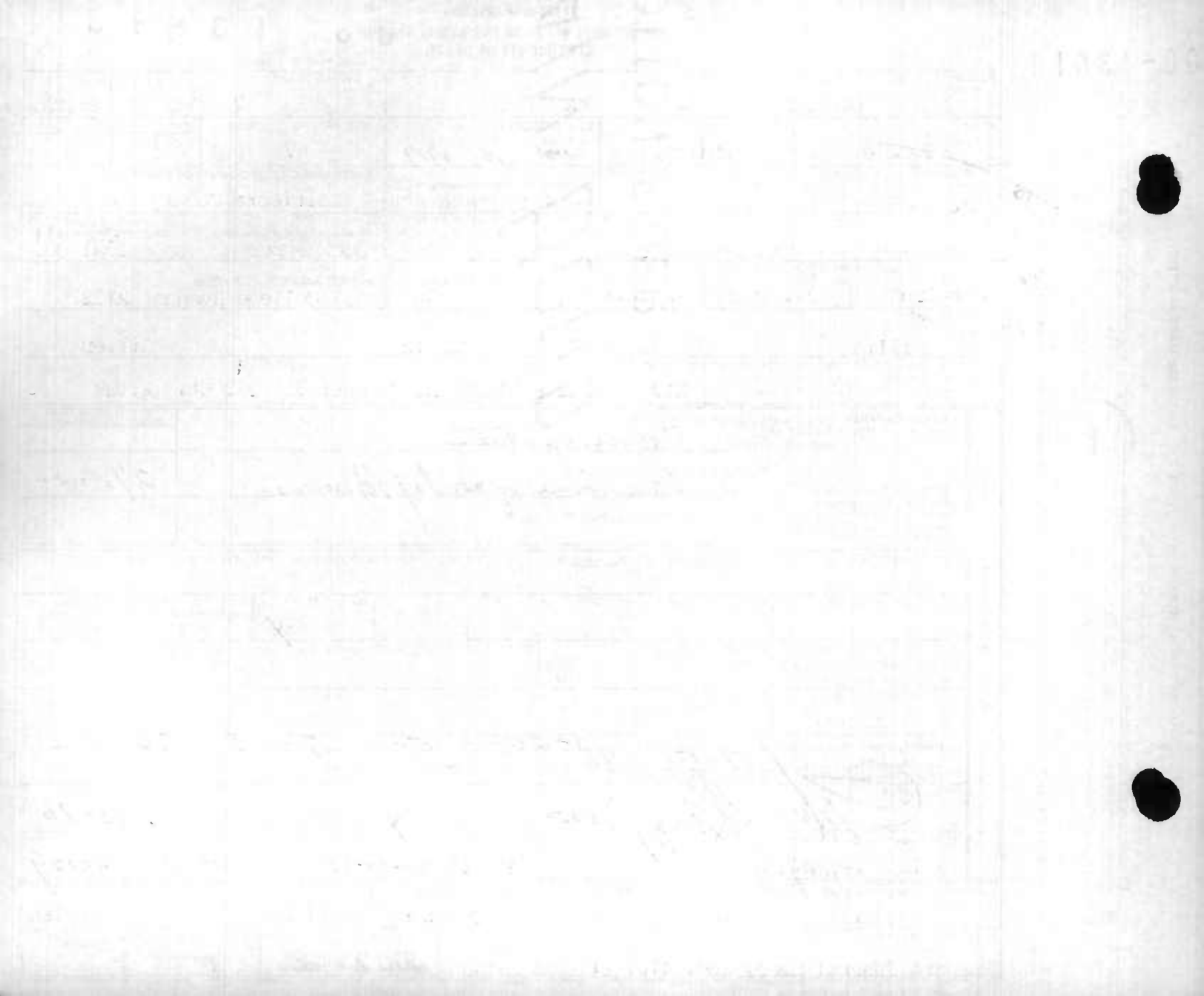
2 1/2 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-25-1984 to 7-18-1986, that (I) (we) lost saw the deceased alive on 7-19-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Harry H. Knipp  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7-18-86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Knipp HARRY H.   |  | 22e. ADDRESS<br>5411 Old Frederick Rd. Suite 20 21229  |  |  |  |   |  |

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                     |  | 23b. DATE<br>7/21/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 21 1986               |  | 25b. REGISTRAR'S SIGNATURE                                       |  |



00-12022

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 2 and 3 should be buried with the body within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this must be reported to the police.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

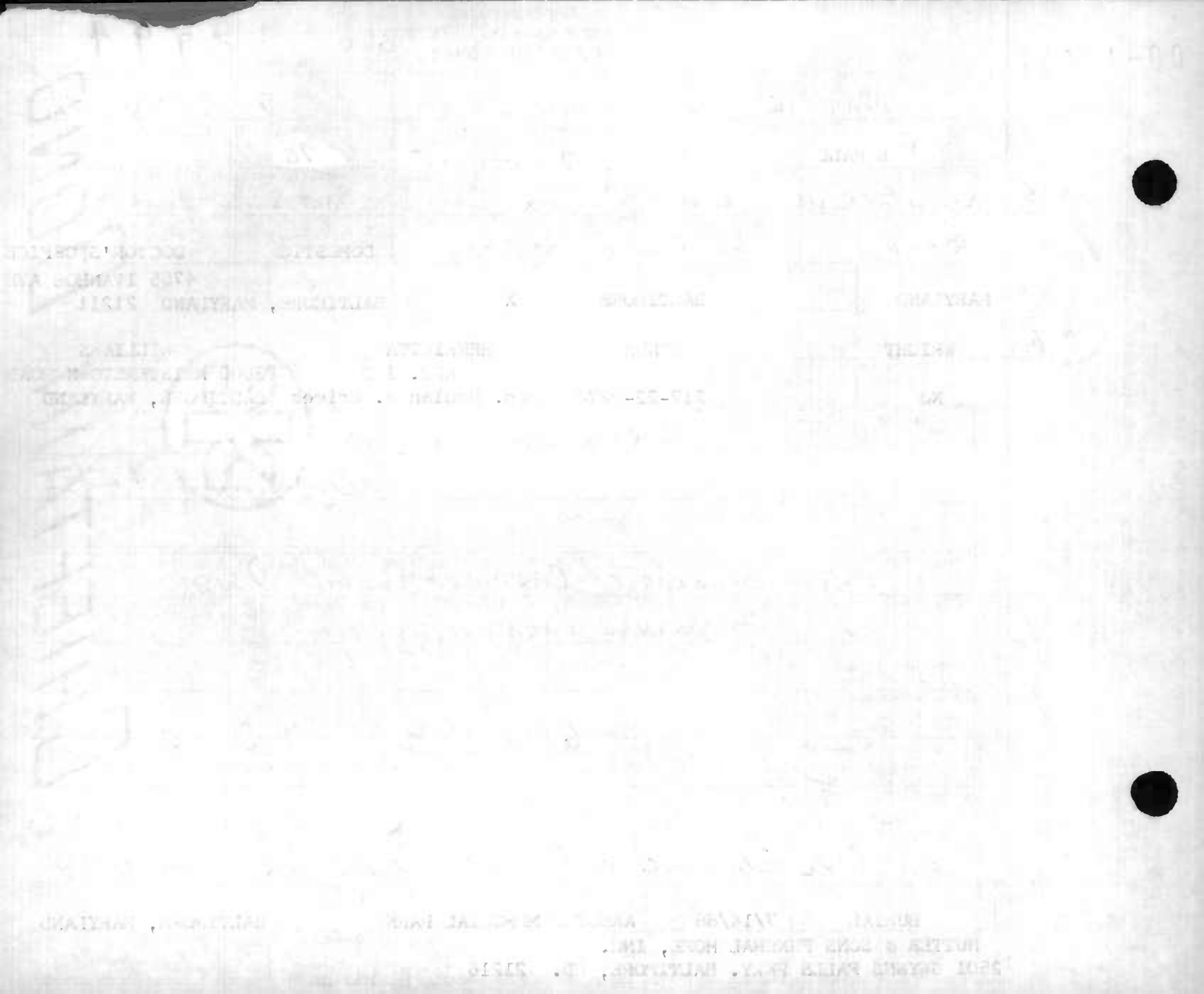
86

REG. NO.

18994

|   |  |   |  |   |   |  |
|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MATTIE B. RANDOLPH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 8 1986</b> |   | 2b. HOUR<br>MIN.<br><b>10<sup>25</sup> A.M.</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 14 1912</b>  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.  |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOCTOR'S OFFICE</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  | 13a. STREET ADDRESS / ZIP CODE<br><b>4705 IVANHOE AVE BALTIMORE, MARYLAND 21211</b>   |   |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MARYLAND</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WRIGHT BYNUM</b>  |  | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HENRIETTA WILLIAMS</b>                                 |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |   |  |
| 17. SOCIAL SECURITY NO.<br><b>217-22-9274</b>   |  | 18. INFORMANT<br><b>APT. 1 D</b>  |  | ADDRESS<br><b>3000 REISTERSTOWN ROAD BALTIMORE, MARYLAND</b>  |   |  |
| 19. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, probably</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>OVARIAN</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos.</b>   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>6-21-86</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ABDOMINAL PARACENTESIS</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6-20-86 7-8-1986 P.M.</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> the hospital attended the deceased from <b>6-20-86</b> to <b>7-8-86</b> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>7-8-1986</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death. |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Wm Carl Ebeling MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7-8-86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm CARL EBELING MD</b>  |  | 22e. ADDRESS<br><b>7401 OSLER DR BALTIMORE</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/14/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>  |  | 24. FUNERAL DIRECTOR<br><b>NUMER &amp; SONS FUNERAL HOME, INC.</b><br><b>2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216</b>     |  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |   |  |

BP



0-13757

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 48 (surgery injury, or other traumatic event, the medical examiner should be notified.)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

18995

1- FOR STATE REGISTRAR Jennie M. Rassa

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Jennie M. Rassa</i>   |   |   | 2a. DATE OF DEATH<br>MONTH <i>7</i> DAY <i>26</i> YEAR <i>86</i>                                |  | 2b. HOUR<br><i>7:30 AM</i>                           |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Caucasian</i>   | 5. DATE OF BIRTH<br>MONTH <i>11</i> DAY <i>12</i> YEAR <i>25</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore Co.</i> MD.       |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Saint Joseph Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Nursing</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Hospital</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <i>Balto.</i> 13c. CITY OR TOWN <i>Bradshaw</i> |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Ignazio</i> MIDDLE <i>Rifici</i> LAST <i></i>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Frances</i> MIDDLE <i>Guiffre</i> LAST <i></i>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>   |   | 16b. SOCIAL SECURITY NO.<br><i>213-20-0107</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Milton Rassa (husband) same address</i> |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Metastatic Pelvic Cancer</i>  |  | <i>3 years</i>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
*Small error*

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION<br><i>None</i>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>None</i>                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. N/A 19</i>                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)<br><i>N/A</i> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>N/A</i> | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>N/A</i>                              |  |

22a. I certify that (I) (this hospital) attended the deceased from *7/10*, 19 *86*, to *7/26*, 19 *86*, that (I) (we) last saw the deceased alive on *7/26*, 19 *86*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

|  |                   |   |                                    |
|--|-------------------|---|------------------------------------|
| 22b. SIGNATURE<br><i>Duane Smoot</i>                             | DEGREE<br><i></i> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><i>7/26/86</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Duane Smoot M.D.</i> |                   | 22e. ADDRESS<br><i>St. Joseph Hospital Inc. 7620 York Rd.</i>   |                                    |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>7/29/86</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto., Md. 21201</i> |
| 24. FUNERAL HOME<br>NAME <i>Schimmek Funeral Home Inc.</i> ADDRESS <i>9705 Belair Road, Balto., Md. 21236</i> |                             | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 29 1986</i>           | 25b. REGISTRAR'S SIGNATURE<br><i>J. R. Rasmussen</i>                   |

BP

208 COLICM PHH16

00-12839

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 86 18996  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| Carl  |  | E  |  |  |  | Rauck  |  | July 14, 1986   |  | 1:53p M                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male  |  | White  |  | 7-14-1899  |  | 87 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Balto. Md.  |  | U.S.A.   |  |  |  | Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Rossville   |  | Franklin Square Hospital   |  |  |  |  |  | Retired   |  | General Motors                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |
| Md.   |  | Balto.   |  | Balto.   |  |  |  | 5510 Kenwood Avenue-21236   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Albert Rauck  |  |  |  | Earnestine Herman  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |  |  |
| No  |  | 216-03-7070  |  | Doris E. Bond  |  | 117 N. Curley St.-21224  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, Hypertension                           |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
|   |  | July 14 1986   |  | July 14 1986   |  |  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from July 14 1986, to July 14 1986, that (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <i>E. Bessman</i>  |  |  |  | DEGREE MD  |  |  |  | 22c. DATE SIGNED July 15, 1986  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Bessman, M.D.  |  |  |  | 22e. ADDRESS 9000 Franklin Square Drive 21237  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 7-17-86  |  | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland                                  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR John C. Miller Inc - 6415 Belair Rd.-21206   |  |  |  | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986  |  | 25b. REGISTRAR'S SIGNATURE <i>Lila Davidson</i>  |  |   |  |  |  |

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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNIE ELIZABETH RAUSCH</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-13-86</b> |   | 2b. HOUR<br><b>3<sup>30</sup> P.M.</b> |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-16-86</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>90 2</b>                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY MD.</b>                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE - RUXTON</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Stork</b>                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Deitz</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>424 S. Smallwood Street 21223</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>         |  | 16b. SOCIAL SECURITY NO<br><b>215-12-8065</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>William F. Sweet 11 Baliffs Court 21093</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**DIABETES MELLITUS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

**STROKE**

MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 85</b> , to <b>7-13 19 86</b> , that (I) (we) lost<br>saw the deceased alive on <b>7-13 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>AH Ghiladi mo</b>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>7-14-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ghiladi</b>   |  |   |  | 22e. ADDRESS<br><b>Osler Med. Building Room 111</b>                           |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                     |  | 23b. DATE<br><b>7/16/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 16 1986</b>               |  | 25b. REGISTRAR'S SIGNATURE  |  |

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of this certificate and file it in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner or public health official must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

7

00-12395

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |                         |   |  |  |  |
|---|-------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MINNIE READMOND</b>   |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 12 86</b>   |  | 2b. HOUR<br><b>7:10</b> M  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 26 1888</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b> YRS.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co. MD.</b>                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KATHERINE Robb N.H.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                 |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET<br><b>5603 Liberty Heights Ave.</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Ziemann</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Feldner</b>  |  | 16. SOCIAL SECURITY NO.<br><b>220-09-8703</b>                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-09-8703</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Baltimore MD 21206</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) - <b>Natural Causes</b> |                         | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Cardiovascular Disease</b>   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Disease</b>                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                     |                         |   |  |  |  |

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>80 7/12/86 SC</b>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/12/86</b> to <b>7/12/86</b> , that (I) (we) last saw the deceased alive on <b>7/12/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert K. Goumnick</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/12/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert K. Goumnick</b>  |  | 22e. ADDRESS<br><b>8726 L. B. St. Baltimore</b>                        |  |  |  |   |  |

|  |  |                             |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>              |  | 23b. DATE<br><b>7-15-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Pk</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 14 1986</b>                |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. A. Davidson</b>                        |  |                             |  | 26. ADDRESS<br><b>8728 Liberty Rd. Randallstown, MD 21133</b>      |  |  |  |

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DHMM-16 25M  
(VRA 15, 4) 1/79

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00-11692

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 1 8 9 9 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |   |   |   |
|---|--|--|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carmen N. REGO</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 6, 1986</b>                |   |   | 2b. HOUR<br><b>9:05P M</b>  |   |   |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 25 1922</b>  |   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>64</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.     |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nelson Co.</b>  |   |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Guiseppi Rego</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Recchione</b> |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 213-18-1639</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy J. Rego</b>  |   |   | Same as 13e   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible Meningitis (Carcinomatosis?)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Lung Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1986</b> , to <b>July 6, 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>July 6, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><i>Dr. Tang</i>   |  |  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>7/6/86</b>                                       |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Tang, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive - 21237</b>   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/10/1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Dundalk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 8 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19000  
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Donothea F. Reinat   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07-22-86   |  | 2b. HOUR<br>10:45 P.M.   |  |
| 3. SEX<br>F   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 14 15   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.s.a.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Thason F. Ford (FSKMC) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>n/a   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul Terry  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Wasjington   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>125164308   |  | 17. INFORMANT<br>ADDRESS<br>Myra C. Perry 20 N. Bentalou Street   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) febrile illness<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) cerebrovascular accident 2 weeks<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br>Previous Cerebrovascular accident   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/16/78 to July 23/86, that (I) (we) lost<br>saw the deceased alive on July 22/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Susan Dexman M.D.   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>7/23/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>7/26/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Chathedral  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc.   |  | ADDRESS<br>1101 East North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19001

|  |  |   |  |   |  |  |   |  |  |                               |  |
|--|--|---|--|---|--|--|---|--|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Loma Ellen Richardson</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 13, 1986</b> |   | 2b. HOUR<br><b>4:08 AM</b>               |  |   |  |  |                               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 8, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>White Marsh 21162</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5905 Ebenezer Rd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>Baltimore</b>                          |   | 13c. CITY OR TOWN<br><b>Middle River</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>208 Middleway Rd. Apt. 1D 21220</b> |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Christopher Crawford</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Lee Thompson</b>   |  |  |   |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212 22 3038</b>   |  | 17. INFORMANT<br>ADDRESS <b>5905 Ebenezer Rd.</b><br><b>Helen E. Surman, Daughter White Marsh, Md.</b>  |  |  |   |  |  |                               |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Hypertensive cardiovascular Disease**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 9a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-7-86</b> , 19 <b>86</b> , to <b>7-13-86</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7-7-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>WYMAN K. WONG</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WYMAN K. WONG</b>  |  | 22e. ADDRESS<br><b>16730 Holabird Rd 21222</b>                         |  |  |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                       |  | 23b. DATE<br><b>7/15/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brzezinski Funeral Home PA 1407 Old Eastern Ave</b> |  |                             |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 14 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson</b>                      |  |

242

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | XC 13525951   |  | REG. NO.  |  | 14002   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>NELSON CARL RIECK  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JULY 27, 1986   |  | 2b. HOUR<br>4:10A <sub>M</sub>  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MARCH 21, 1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ASSEMBLY WORKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE MARYLAND   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GUSTAV CARL RIECK   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELSIE LENA GADOW  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>W.W. 11   |  | 17. INFORMANT ADDRESS<br>213 18 5088  |  | CLINICAL RECORDS, VAMC, FORT HOWARD, MD   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY CANCER WITH METASTASIS<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from JUNE 17, 19 86, to JULY 27, 19 86, that (X) (we) lost above, (X) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <i>Bala S. Duggirala</i>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br>JULY 27, 1986   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BALA S. DUGGIRALA, M.D.   |  |   |  | 22e. ADDRESS<br>VA MEDICAL CENTER, FORT HOWARD, MD 21052  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>7/29/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Junior Order  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Preston Caroline Md                    |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>THOMAS FUNERAL HOME CAMBRIDGE, MD.  |  |   |  | 25a. TIME RECEIVED BY REGISTRAR<br>31 JUL 31 1986   |  |   |  |   |  |

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00-11846

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19003  
REC. 110

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James H. Roberts, Sr.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>7</b> YEAR <b>86</b>                        |   | 2b. HOUR<br><b>9:40</b> A.M.  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>18</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. Co.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BGE</b>   |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>W.</b> LAST <b>Roberts</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nora</b> MIDDLE <b>Ruth</b> LAST <b>Franklin</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212 076107</b>   |  | 17. INFORMANT<br><b>Margaret A. Cook Westminster, MD</b>                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asystolic Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic Coronary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b><br><b>Atrial &amp; Ventricular Arrhythmias</b>              |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> , 19 <b>80</b> , to <b>7/7</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/7/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Steven Steinhilber MD</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>7/7/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN STEINHILBER</b>  |   | 22e. ADDRESS<br><b>3502 CROYDON RD</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>7-10-86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Sykesville</b> COUNTY <b>Carroll</b> STATE <b>MD</b> |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Haight Funeral Home</b> ADDRESS <b>Sykesville, MD</b>   |   | 25a. DATED <b>JUL 9 1986</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |   |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

CH

86 19004

Handwritten notes on lined paper, including the phrase "I am a ...".

Top section: Faint handwriting, possibly "I am a ...".

Middle section: "I am a ...".

Bottom section: "I am a ...".

00-12964

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 19005

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNE ROSENBAUM  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 13, 1986   |  | 2b. HOUR<br>6:40 AM   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>AUG. 15, 1910   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN NURSING HOME                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>HOMEMAKER   |  | 13a. STREET ADDRESS / ZIP CODE<br>6117 BARTOL AVE. (21209)   |  |   |  |
| 13b. CITY OR TOWN<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sandra SATOSKY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH RUTKOWITZ   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>213-68-3465  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Sandra Gutman 2306 W. Rogers Ave. (21209)                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>YKS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/3/86</u> to <u>7/13/86</u> that (I/we) lost saw the deceased alive on <u>8/3/86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (and not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Kenneth M. Zonick</u>   |  |  |  | 22c. DATE SIGNED<br>7/14/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KENNETH ZONICK  |  |  |  | 22e. ADDRESS<br>1777 Reisterstown Rd Pk 10 suite  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>7/15/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI TFILOH CONG.                                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN, BALTO, MD.   |  | 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  | 25a. DATE REC'D BY REGISTRAR<br>JUL 21 1986   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



0-13267

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 19006

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lena Elizabeth Robinson</b>   |  |   | 2a. DATE OF DEATH<br><b>July 22 1986</b>   |   | 2b. HOUR<br><b>M</b>                               |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br><b>May 26 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridan Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Weaver</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> |  |   | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Woodlawn</b>                  |  |
| 14. FATHER'S NAME<br><b>Charles Chalk</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-4371</b>  |  | 17. ADDRESS<br><b>Mr. Calvin Robinson<br/>2107 Triandos Drive<br/>Timonium<br/>21093<br/>Maryland</b> |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dementia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dehydration</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> , to <b>July 15</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Barathona</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARATHONA LEONEL</b>  |  |  |  | 22e. ADDRESS<br><b>1101 MAIDEN CHOICE LANE 21229</b>                                 |  |   |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <b>Burial</b>  |  | 23b. DATE<br><b>7-24-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel Prince Georges Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc.</b><br>ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. A. Davidson</b>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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July 22, 1950

John F. Kennedy, Boston

60

July 22, 1950

Washington

Mr. A. J. Felt

Washington

Washington

Washington

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00-13006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

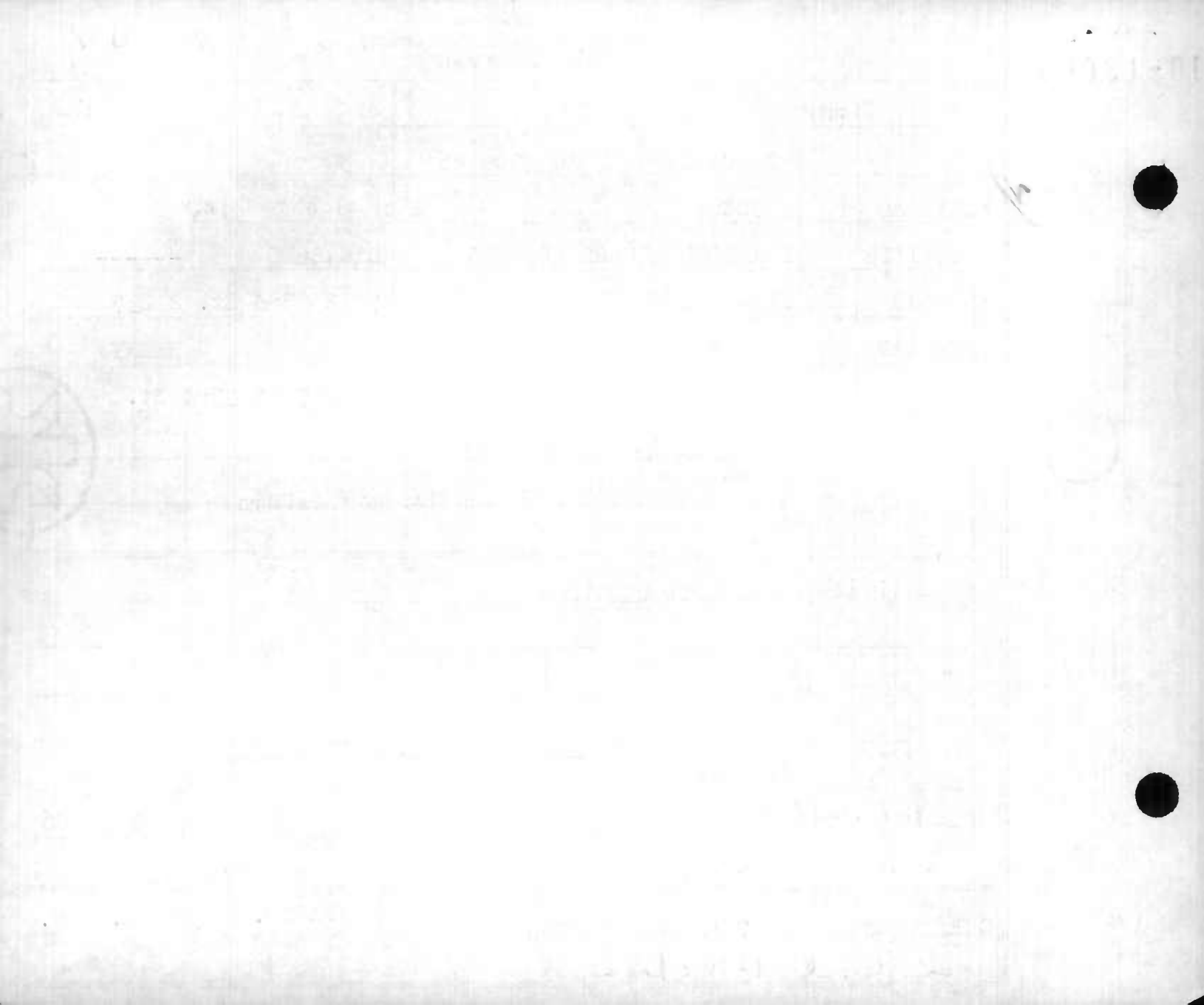
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove outstanding Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic cause, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  | 8 6 1 9 0 0 7  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a DATE OF DEATH   |  |   |  | 2b HOUR   |  |
| Richard Lee ROBINSON   |  |   |  | July 21, 1986  |  |   |  | 6:15A <sub>M</sub>  |  |
| 3. SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |  |
| MALE   |  | CAUCASIAN   |  | MONTH 10 DAY 20 YEAR 46  |  | 39 YRS.   |  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |   |  |
| MARYLAND   |  | USA   |  |  |  | Baltimore County MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |
| ROSSVILLE  |  | FRANKLIN SQUARE HOSPITAL  |  |  |  | DISABLED  |  | -----   |  |
| 13a STATE  |  |   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?   |  |
| MARYLAND   |  |   |  | BALTIMORE  |  | ROSEDALE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME   |  |   |  | 15 MOTHER'S MAIDEN NAME  |  | 13e STREET ADDRESS / ZIP CODE                                       |  |   |  |
| BERNARD ROBINSON   |  |   |  | IDA HENRY  |  | 7912 33rd St. 21237   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |  |   |  |   |  |
| NO   |  | 218463110   |  | DEBBIE ROBINSON 7912 33rd St.  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Edema/Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Insulin Dependent Diabetes Mellitus</u>   |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |
|  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
|  |  |   |  |  |  |   |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from <u>June 18, 1986</u> to <u>July 21, 1986</u> that (I) (we) lost<br>saw the deceased alive on <u>July 21, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |   |  |
| 22a SIGNATURE<br>  |  |   |  | DEGREE   |  |   |  | 22c DATE SIGNED   |  |
|  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |   |  | 07/21/86  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e ADDRESS  |  |   |  |   |  |
| Julio P. Ruiz, M.D.  |  |   |  | 9000 Franklin Square Drive- 21237  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION  |  |   |  |
| CREMATION  |  | 07/23/86  |  | WESTVIEW   |  | BALTO. BALTO. MD.   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |   |  | 24b ADDRESS  |  | 25a DATE REC'D. BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE   |  |
|  |  |   |  | 1211 Chesapeake Ave.   |  | JUL 21 1986   |  |   |  |



00-12510

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked as "true", then any injury, or other traumatic event, the medical examiner may be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 86 19008   |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| Anna May Rohlfing   |  |  |  |  |  | July 9 1986   |  | M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| Female  |  | Caucasian  |  | May 1 1901   |  | 85  |  | YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |
| Maryland  |  | USA  |  |  |  | Baltimore County MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Randallstown  |  | Baltimore County General Hospital  |  |  |  | Asst. Comptroller   |  | Mangels-Herold  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| Maryland  |  | Baltimore  |  | Owings Mills   |  | 13e. STREET ADDRESS / ZIP CODE  |  | 21117   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                              |  | 17. INFORMANT ADDRESS   |  |
| William Guinn Dixon   |  | Viola MacKenzie  |  | No   |  | 212-03-7074   |  | Mrs. Joy Ferris 20707 Maryland  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) MASSIVE GT bleed, hypertension  |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | ASCVD, long-standing cardiomyopathy  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 7-6 to 7-9 1986, that (1) (we) lost saw the deceased alive on 7-9 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE DEGREE   |  | 22c. DATE SIGNED   |  |  |  |   |  |   |  |
| BARRY G. Walters  |  | 7-9-86   |  |  |  | 7-9-86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |
| BARRY G. Walters  |  | 3502 Croydon RD  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| Entombment  |  | 7-11-86  |  | Lorraine Park Mausoleum  |  | Woodlawn Baltimore Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |
| Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133   |  | JUL 14 1986  |  | J. J. Anderson   |  |   |  |   |  |



00-11466

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19009

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST Bernard MIDDLE Carl LAST Roob<br><b>Bernard Carl Roob</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 2 86<br>2b. HOUR<br>11:25 PM |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 16 1916                                       |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris Hospice |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County                                  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Monkton  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael B. Roob  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Lhota  |   | 17a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Industrial Specialist |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -   |  | 16b. SOCIAL SECURITY NO.<br>272-05-2819   |   | 17b. KIND OF BUSINESS OR INDUSTRY<br>Defense Contracts                                    |  |
| 17c. STREET ADDRESS / ZIP CODE<br>3936 Stansbury Mill Rd. 21111  |  | 17d. ADDRESS<br>3936 Stansbury Mill Rd.   |   | 17e. ADDRESS<br>3936 Stansbury Mill Rd.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Illness</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____            |  |   |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Prostate Cancer with lung mets.</u>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> 19 <u>86</u> , to <u>7/2</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>7/2</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><u>K R Faulkner MD</u>   |  | DEGREE  |   | 22c. DATE SIGNED<br>7/2/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kendall R. Faulkner, M.D.   |  | 22e. ADDRESS<br>Stella Maris Hospice<br>2300 Dulany Valley Rd. - Towson, MD 21204   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(158c-81)<br>Burial   |  | 23b. DATE<br>7/7/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Chestnut Grove Pres. Ch. Cem.                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Phoenix Balto. Md.   |  | 23e. DATE REC'D. BY REGISTRAR<br>JUL 7 - 1986   |   | 23f. REGISTRAR'S SIGNATURE<br><u>Martin D. Lawson</u>                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson, 10 W. Padonia Rd. 21093  |  |   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21b, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Room 101

101-101-101

101-101-101

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00-12972

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19010

|  |                              |  |  |  |  |   |  |
|--|------------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| Marie  |                              | Rose   |  | JULY 18 86   |  | 2120 p.m.   |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| Female   | Cauc.                        | 9 8 07   |  | 78 YRS.  |  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland   | U.S.A.                       |  |  | Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Dundalk  |                              | Meridian Nursing Center-Heritage   |  | homemaker  |  | home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE   |                              | 13b. CITY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| Maryland   |                              | Baltimore  |  |  |  | 13e. STREET ADDRESS / ZIP CODE  |  |
|  |                              |  |  |  |  | 417 S. East Ave., 21224   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |                              | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |   |  |
| John Ramiszewski   |                              | Anna Bragoszewski  |  | 21224  |  |   |  |
| 16a. NO  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
|  |                              | 213-01-5185D   |  | Mrs. Mildred Tudor, 417 S. East Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.P.C.V.D.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 week</u> <u>YEARS</u> |                              |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |                              |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1982</u> to <u>July 8, 1986</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |                              |  |  |  |  |   |  |
| 22b. SIGNATURE   |                              | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |
| <u>B. C. Veneracion Jr MD.</u>   |                              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 7/18/86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              | 22e. ADDRESS   |  |  |  |   |  |
| B. C. VENERACION JR MD.  |                              | 3401 Dundalk Ave BALTO MD 21224  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |                              | 7/22/86  |  | Baltimore National   |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME  |                              | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Joseph N. Zannino, 263 S. Conkling St.   |                              | JUL 21 1986  |  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, including the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 will be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be advised of this.

FILED IN

2002 COLLON

John

Investment

and

Investment  
2002

and Investment, 17 St. Paul Ave

Investment and Investment, 17 St. Paul Ave

Investment and Investment, 17 St. Paul Ave

Investment and Investment, 17 St. Paul Ave

Investment and Investment, 17 St. Paul Ave

Investment and Investment, 17 St. Paul Ave

00-11647

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN S ROWLETTE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>2</b> YEAR <b>86</b> 2b. HOUR <b>6.30P.M.</b>        |   |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>7</b> YEAR <b>1918</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CO. GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber Shop</b> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |

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|--|---|---|--|
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Samuel</b> LAST <b>Rowlette</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Martha</b> MIDDLE <b>E.</b> LAST <b>Brown</b>                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b> | 17. INFORMANT<br><b>Mary Rowlette</b> ADDRESS <b>3608 Forest Park Avenue, Baltimore, Maryland 21216</b> |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma lung.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                          |  |   |

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |   |   |  |
|---|---|---|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-1</b> , 19 <b>86</b> , to <b>7-2</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7-2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |
| 22b. SIGNATURE<br><b>Rayadurga Govinda</b>  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>7.2.86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYADURGA GOVINDA MD</b>  |   | 22e. ADDRESS<br><b>BALT. COUNTY GENL HOSPITAL</b>                             |  |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>      | 23b. DATE<br><b>7/7/1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veteran</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL REGIONS<br><b>NOTTER &amp; Sons Funeral Home, Inc.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 8 1986</b>                   | 25b. REGISTRAR'S SIGNATURE   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WHEATLAND

COTTON FIBERS

JUL

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0-13352

#15, F11MG619 9/20/86 kam  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR  
CERTIFICATE OF DEATH

19012

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARETE Rubendall</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br><b>7 23 86 11:28 M</b>                   |  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 2 21</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Timonium</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>71 Northwood Dr. 21093</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Gorbach</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Muller</b>             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>177-18-0082</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Edward I. Rubendall-Same as #13</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diffuse abdominal mets</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ovarian cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 19 86</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-17-86</b> to <b>7-23-86</b> , that (I) (we) last saw the deceased alive on <b>7-23-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>K R Faulkner MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7-23-86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall R. Faulkner, M.D.</b>   |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>2300 Dulaney Valley Rd.-Towson, MD 21204</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>7-23-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1986</b>                                  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rudner</b>  |  |  |   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Over the course of the study, the researchers found that the most common reason for the lack of a clear definition of the term "community" was the lack of a clear definition of the term "community".

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00-13638

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 19013

REG. NO.

|  |  |  |  |  |                     |  |
|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIOLET M. RUHS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 26, 1986 |  | 2b. HOUR<br>9:38A M |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 31 22  |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                     |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk  |                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>May Co.   |  | 13a. STREET ADDRESS / ZIP CODE<br>3337 Bels Fort Court 21222   |  |  |                     |  |
| 13b. COUNTY<br>Maryland  |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Reed   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose J. Phillips  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-22-5475   |  | 17. INFORMANT<br>ADDRESS<br>Victoria Wilson F.J.J. 3337 Bels Fort Ct. 21222  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest, Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hyperglycemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Congestive heart failure<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Severe peripheral vascular disease, Bilateral carotid disease  |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |                     |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                     |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 25, 1986, to July 26, 1986, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 26, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |  |  |                     |  |
| 22b. SIGNATURE<br><i>Babar Yousaf</i>  |  | DEGREE   |  | 22c. DATE SIGNED<br>7/26/86  |                     |  |
| 22d. PHYSICIAN NAME (TYPE OR PRINT)<br>Babar Yousaf, MD  |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/31/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk. A.A. Maryland   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229   |  |  |                     |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JUL 28 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard J. ...</i>  |  |  |                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is an injury, or other traumatic event, the medical examiner must be notified.

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00-14003

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 19014

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dale W. RUNNER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 30, 1986</b>            |   |   | 2b. HOUR<br><b>1:05 a.m.</b>   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18 1922</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Body-Fender</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |  |   |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harlow Runner</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Funk</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>232-24-3349</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Marjorie Runner 7515 Durwood Rd. 21222</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>Cardiac Arrest</b><br>IMMEDIATE CAUSE (a)<br><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Congestive Heart Failure, End Stage Cardiac Disease</b><br>(b)<br><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Atrial Fibrillation</b><br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a  |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>July 17</b> , 19 <b>86</b> , to <b>July 30</b> , 19 <b>86</b> that (he) (we) last saw the deceased alive on <b>July 30</b> , 19 <b>86</b> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Sam Toueg</i>  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>07/30/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sam Toueg, M.D.</b>   |  |  | 22e. ADDRESS<br><b>9000 Franklin Sq. Dr., 21237</b>                    |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>7/31/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Connelly F.H.</b>  |  |  | 7110 Sollers Point Road<br><b>Dundalk 21222</b>                        |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julie Davidson-Randall</i>  |  |

3 1/2 COTTON 11-65

CHITELINE 11-65



00-14215

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |   |  |   |  |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEON EDWARD RUTHENBERG</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 30, 1986</b>            |   | 2b. HOUR<br><b>2 P.</b> M   |  |   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 12, 1922</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>MARYLAND BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3218 MARNAT RD.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BO BROOKS</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3218 MARNAT RD. #21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MEYER RUTHENBERG</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE HAMERNICK</b> |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWII-NAVY 216-12-7006</b>  |  | 17. INFORMANT <b>MRS. RONA LEE RUTHENBERG</b><br><b>3218 MARNAT RD. BALTO., MD 21208</b>  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes and hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><br><u>6725</u>  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>kidney failure</u>   |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>7/29</u>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1983</u> to <u>July 29</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>7/29</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>James H. Messey</u>   |  |   | DEGREE<br><u>MD</u>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>7/30/86</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JAMES H. MESSEY</u>  |  |   | 22e. ADDRESS<br><u>6701 N. CHARLES ST 21204</u>                        |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>AUG. 1, 1986</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEM. PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   | 25a. DATE REG'D. BY REGISTRAR <b>AUG 5 1986</b><br>25b. REGISTRAR'S SIGNATURE<br><u>James H. Messey</u> |  |   |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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21511-00

00-13030

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19016

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES ERNEST RYLEE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-17-86 11<sup>05</sup>A</b>                          |   | 2b. HOUR<br><b>11<sup>05</sup>A</b> M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-15-1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales manager</b>        |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>Lutherville</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>125 LAROCK DR. 21095</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Hampton Rylee</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice M. Nixon</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>253-05-2283</b>   |   | 17. INFORMANT ADDRESS<br><b>Marjorie E. Rylee - same as #13e</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ascvd w recurrent MI + CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>nephrosclerosis uremia</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> 19 <b>65</b> , to <b>7/17</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/17</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>D. A. Oursler</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/17/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. A. Oursler MD</b>  |   | 22e. ADDRESS<br><b>7401 Osker Dr</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>7-18-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |   | 23e. NAME OF FUNERAL DIRECTOR<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>1050 York Rd.</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 21 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                              |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as above, item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-12776

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

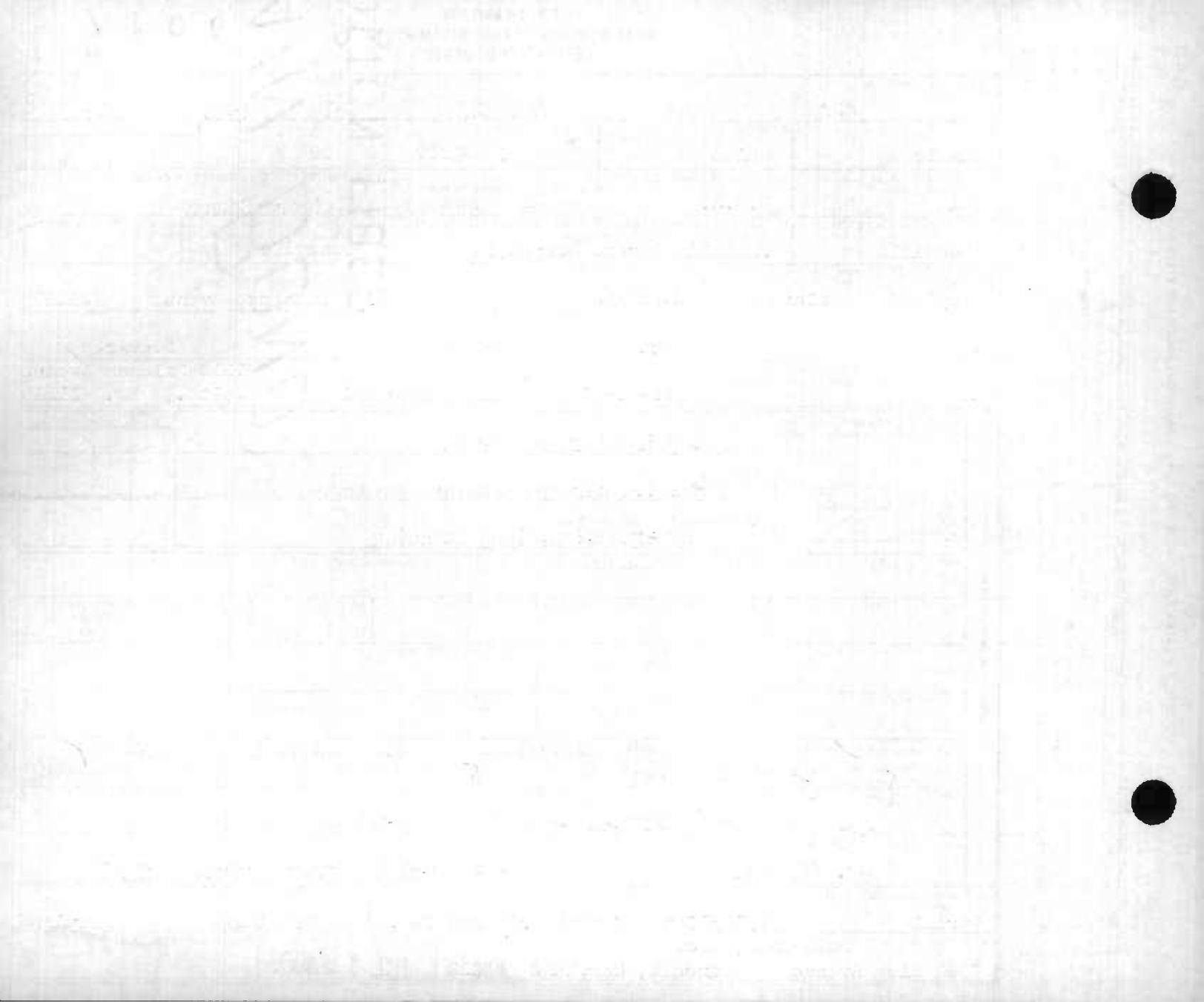
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Anna SAKOWSKI  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 15, 1986                   |   |  | 2b. HOUR<br>7:27 PM  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 9 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Ernaklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Rosedale  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>309 Patapsco Avenue 21237 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul Kutz  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Schwartz       |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>213-09-2723                                |   | 17. INFORMANT<br>George Sakowski   |  | ADDRESS 7318 Waldman Avenue<br>Balto., MD. 21219  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Massive cerebrovascular accident<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertension, long standing<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from July 15, 19 86, to July 15, 19 86, that (we) last saw the deceased alive on July 15, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Dr. Wilkinson  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Wilkinson   |  |   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>7/18/1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Christ Lutheran Cem.                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1986   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |
| 7922 Wise Avenue Dundalk, Maryland 21222   |  |   |  |   |  |  |   |  |   |  |

BP



0-13313

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19018

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James VERNON SAMELKO                 |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 21, 1986                          |  | 2b. HOUR<br>4:28PM  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 27 1914   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |   |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>REEL YARD | 12b. KIND OF BUSINESS OR INDUSTRY<br>WEST. ELECT             |   |
| 13a. STATE<br>MD  |   |  | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>ROSEDALE                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN --- SAMELKO                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA --- SZIERZPUTOWSKA      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   | 17. INFORMANT<br>ADDRESS<br>HEDWIG K. SAMELKO 1705 SUMMIT AVE                 |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from July 21, 1986, to July 21, 1986, that (I) (we) last saw the deceased alive on July 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>Susan Wilkinson</i>   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Susan Wilkinson, M.D.   |  | 22e. ADDRESS<br>9000 Franklin Square Drive- 21237                      |  |  |   |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(5) BURIAL  | 23b. DATE<br>7/25/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO BALTO MD |
| 24. FUNERAL DIRECTOR<br><i>1211 Chesapeake</i> |                      | 25a. DATE RECD. BY REGISTRAR<br>JUL 23 1986       | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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101 83 101

00-11656

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19019

|  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAURENCE PURDY SANGSTON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 7, 1986</b>             |   | 2b. HOUR<br><b>6:30P M</b>  |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 19, 1901</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summit Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland State</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. STREET ADDRESS / ZIP CODE<br><b>1216 Black Friars Road 21228</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Allan Sangston</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte Louise Purdy</b>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF TYPE "A" OR "B" OR "C" OR "D")<br><b>WW 11</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Alban Kroh Sangston Same as # 13</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Chronic Obstructive Lung Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cigarette Smoking</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20yrs</b><br><b>&gt;50yrs</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Cor Pulmonale, Arteriosclerotic Cardiovascular Disease</b>  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> 19 <b>83</b> , to <b>July</b> 19 <b>86</b> , that (I) <b>yes</b> last saw the deceased alive on <b>July 2</b> 19 <b>86</b> , and that in (my) <b>best</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>did</b> (did not) view the body after death.        |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Jay Gerstenblith, MD</b>  |  |   |  |   |   | DEGREE  |  | 22c. DATE SIGNED<br><b>7/8/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jay Gerstenblith M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>St. Agnes Medical Center Suite 204<br/>3455 Wilkens Avenue, Baltimore, MD. 21229</b> |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>7/11/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cwings Mills Maryland</b>       |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 8 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson</b>   |  |
| 1630 Edmondson Avenue, Catonsville, MD. 21228  |  |   |  |   |   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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General Charles F. Smith  
General Smith of

General Smith of

General Smith of

General Smith of

11

0-13660

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9021  
REG. NO.

|  |  |                      |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <u>July 22 1986</u> 11P |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>JOSEPH L. SCHAFER</u>  |  |                      |  |  |  |  |  |  |  | 2b. DATE OF DEATH <u>July 22 1986</u> 1P                  |  |  |  |  |  |  |  |  |  |
| 3. SEX <u>MALE</u>   |  | 4. RACE <u>WHITE</u> |  | 5. DATE OF BIRTH <u>AUG. 19, 1920</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS. |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 7c. DATE PRONOUNCED DEAD <u>July 22 1986</u> 1P           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE</u> MD |  |  |  |  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>  |  |                      |  | 11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SELF-EMP.</u> |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>  |  |  |  |  |  |  |  |
| 13a. STATE <u>MARYLAND</u>   |  |                      |  | 13b. CITY OR TOWN <u>BALTIMORE</u>   |  |  |  | 13c. STREET ADDRESS <u>5821 FAIRWOOD AVE</u>                                   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>EDWARD F. SCHAFER</u>   |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>M. E. LOWMAN</u>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>YES</u>  |  |   |  | 16b. SOCIAL SECURITY NO. <u>W.W.II</u>   |  |  |  |  |  |  |  |
| 17. INFORMANT <u>FAMILY RECORDS</u>  |  |                      |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD with coronary</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Insufficiency</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH <u>Sudden</u><br><u>5 yrs</u>     |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |                      |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. Donnelly</u>  |  |                      |  | TITLE (SPECIFY) <u>Deputy</u>  |  |  |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED <u>7/23/86</u>   |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                      |  | ADDRESS  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |  |                      |  | 23b. DATE <u>7-26-86</u>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>DULANSY VALLEY</u>                       |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Timonium BALTO. MD.</u>   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>EVANS CHARLOF MEMORIAL</u>  |  |                      |  | ADDRESS <u>8800 HARFORD ROAD</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>JUL 25 1986</u>                               |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendell</u>   |  |  |  |  |  |  |  |

1932

John D. Hill  
July 1911

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry to hear that you are not satisfied with the results of the investigation. I have been unable to obtain any further information from the sources mentioned in your letter.

I am sure that you will understand the difficulties of the situation. I am sure that you will be satisfied with the results of the investigation.

I am, Sir, very respectfully,  
Yours truly,  
John D. Hill



10-13548

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19022  
REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna SCHAFER</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21, 1986</b>                                     |  | 2b. HOUR<br><b>10:45 PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 7 05</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                            |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Balto</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Schroll</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret</b>                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-03-0305D</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Joyce Reckenberger, 944 Elton Avenue<br/>Baltimore, Md.</b> |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atrial Fibrillation with Rapid Ventricular Rate</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Airway Disease</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>June 26</b> , 19 <b>86</b> , to <b>July 21</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>July 21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. M. El Nahal, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>7/21/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohamed Hany El Nahal, M.D.</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Hospital</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |
| 23b. DATE<br><b>7-25-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ann M. Matthews, Matthews Funeral Home</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 28 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 25c. ADDRESS<br><b>3021 Eastern Ave., Baltimore, Md. 21224</b>  |  |   |  |  |  |

100% COTTON

NOTED

100% COTTON

CHERRY LANE



00-12867

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 86 19023  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>AUDREY SCHALLA</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7 15 '86</b>  |  |   | 2b. HOUR<br><b>9:45A</b> M                               |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 20 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Balto. Med. Ctr.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   |  |   |  | 13b. CITY OR TOWN<br><b>Balto.</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>5737 Maple Hill Rd. 21239</b>        |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Irving Austin</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lily Wilson</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-5117</b>  |  | 17. INFORMANT ADDRESS<br><b>261 Nottingham Rd. Ms. Joanne Marquart Sherwood Forest</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARDS, SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>7-11 19 86</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-11</b> , 19 <b>86</b> , to <b>7-15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>L. Kauffman MD.</b>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>7/15/86</b>                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. KAUFFMAN, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>GBAC-6701 N. CHARLES ST.-21203</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |   |  | 23b. DATE<br><b>7-15-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1986</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tindon-Radner</b> |  |  |

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0-12389

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the death certificate, and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- STATE REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 1 9 0 2 4  
 CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MARY MIDDLE GRACE LAST SCHSIOT  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR June 30, 1986  |   | 2b. HOUR 6:30 P  |
| 3. SEX Female   | 4. RACE WHITE   | 5. DATE OF BIRTH MAY 12, 1894  | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS  | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.   |   |  |
| 10. CITY OR TOWN OF DEATH Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Maryland   |   |  | 13b. COUNTY Balt  | 13c. CITY OR TOWN Baltimore   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. SEABRASE   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE KROUSE   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |   | 16b. SOCIAL SECURITY NO. 216 015830  | 17. INFORMANT ADDRESS FAMILY RECORDS  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) stroke<br>DUE TO, OR AS A CONSEQUENCE OF (b) organic Brain sd<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 6/30/ 19 86, that (I) (we) lost saw the deceased alive on 6/18/ 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |   |  |   |   |  |
| 22b. SIGNATURE [Signature] DEGREE   |   |  | 22c. DATE SIGNED July 1, 1986   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUONG NGUYEN   |
| 22e. ADDRESS 6331 BEL AIR ROAD Balto Md 21206   |   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  | 23b. DATE 7-2-1986  | 23c. NAME OF CEMETERY OR CREMATORY MORELAND PARK   | 23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO MD  |   |  |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPL OF MEMORIES HARFORD   |   | 25a. DATE REC'D BY REGISTRAR JUL 14 1986   |   | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

BP



00-12113

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

19025

|  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL</b> <b>SCHERR</b>   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>07-05-86</b>                     |  |   | 2b HOUR<br><b>1630</b>   |  |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>caucasian</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>08-24-18</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO.</b> MD.   |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>RANDALLTOWN</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CO. GEN. HOSP.</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Communication Officer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Police</b>  |   |  |
| 13a STATE<br><b>MD.</b>  |  |  | 13b COUNTY<br><b>BALTO.</b>  |  | 13c CITY OR TOWN<br><b>RANDALLTOWN</b>  |  | 13d INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 13e STREET ADDRESS / ZIP CODE<br><b>9058 Hlenswood Rd. Randallstown 21133</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Scherr</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Rahm</b>       |  |   | ADDRESS <b>Silver Springs, MD</b>  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b> |  | 17 INFORMANT<br><b>Sonia Josephs</b>  |  | ADDRESS <b>1812 Snowdrop Ln</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Approximate interval between onset and death <b>30 min</b><br><b>#16 &amp; 115</b> |  |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a<br><b>card. myoc. infarct con</b>   |  |  |  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/10</b> 19 <b>85</b> to <b>7/5</b> 19 <b>86</b> , that (I) (last saw the deceased alive on <b>3/24/86</b> 19 <b>86</b> , and that in (my) (opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><b>Donald H. Egan</b>   |  |  | DEGREE<br><b>M.D.</b>  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c DATE SIGNED<br><b>7/16/86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald H. Egan</b>  |  |  | 22e ADDRESS<br><b>BALTIMORE F. CARAN</b>                               |  |   | 22f ADDRESS<br><b>2435 W. BELVEDERE AVE.</b>   |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>7/7/86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Bnei Israel</b>                       |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD.</b>   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hebrew Memorial F.H.</b>   |  |  |  |  |   | ADDRESS<br><b>1100 Reisterstown Rd</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 11 1986</b>   |   |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |  |   |  |  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be retained by the funeral director. Page 4 will be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

6113 100-202

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |  |  |  |  |   |  | REG. NO. 9 0 2 6  |  |
|--|-------------------------|--|---|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HERBERT</b> <b>SCHNITZER</b><br>(AKA) <b>D. Daniel Powers III</b>   |                         |  |   |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <b>7</b> DAY <b>20</b> YEAR <b>1986</b> HOUR <b>48</b> M <b>48</b> |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH <b>OCT.</b> DAY <b>30</b> YEAR <b>1938</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>47</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>7</b> DAY <b>20</b> YEAR <b>1986</b> HOUR <b>48</b> M <b>48</b> |  | 7b. HOUR  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b>  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3313 SMITH AVE. 21208</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>                             |  |   |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 13e. STREET ADDRESS<br><b>3313 SMITH AVE. 21208</b>                                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>PAUL</b> MIDDLE <b></b> LAST <b>XXX SCHNITZER</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>YETTA</b> MIDDLE <b></b> LAST <b>SELTZER</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>216-26-7849</b>   |   | 17. INFORMANT #21215 ADDRESS<br><b>MRS. BETTY NEWMAN 6317 PARK HEIGHTS AVE.</b>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gum stab wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>     |                         |  |   |  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Stanley Z. Gelbenberg</b>   |                         | TITLE (SPECIFY)<br><b>Deputy</b> MEDICAL EXAMINER  |   |  |  |  |  | DATE SIGNED<br><b>7/21/86</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Stanley Z. Gelbenberg MD</b>  |                         | ADDRESS<br><b>11 E. Chase St 21202</b>   |   |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>7/22/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OHEL YAKOV CEM</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MARYLAND</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |                         |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                 |  |   |  |

1935  
1936  
1937

1938  
1939  
1940  
1941



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19027

REG. NO.

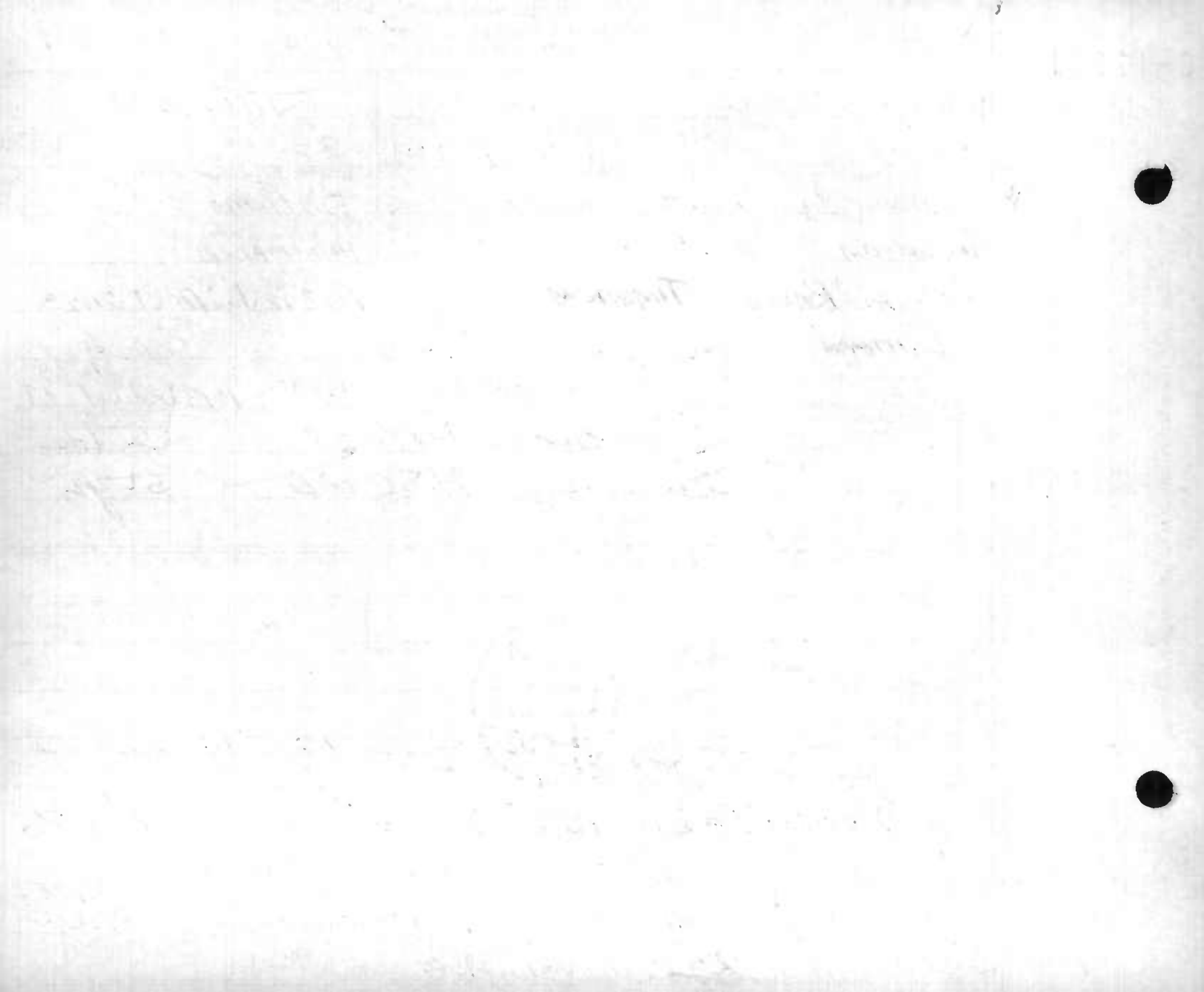
1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |  |
|---|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Catherine Schoed  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 12 86 |   |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 1 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Syracuse, N.Y.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>IMMORTUM   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALD Med Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |  |
| 13a. STATE<br>Maryland  |  |  |   | 13b. COUNTY<br>BALD   |  | 13c. STREET ADDRESS<br>1013 Dedwith CT 21093                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edmond Dwyer  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen Roach  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-44-238  |   | 17. INFORMANT<br>ADDRESS<br>M's Joan Butler 1013 Dedwith CT 21093   |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF, <u>Generalized ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>5 yr</u>                   |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) <u>(was hospital)</u> attended the deceased from <u>2 June 86</u> to <u>12 July 1986</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>2 June 86</u> , and that in my <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> did not view the body after death. |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Charles F. O'Donnell</u>   |  |  |   | 22c. DATE SIGNED<br>7/13/86   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES F. O'DONNELL   |  |  |   | 22e. ADDRESS<br>7501 YORK RD. Towson, MD.   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>B   |  | 23b. DATE<br>7-16-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ASSUMPTION  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Syracuse N.Y. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  |  |   | 24b. ADDRESS<br>222 W. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 14 1986                |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-11970

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19028  
REG. NO.

|  |  |  |  |  |               |   |
|--|--|--|--|--|---------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Maria M. Scilipoti</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8, 1986</b> |  | 2b. HOUR<br>M |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>white</b>                      | 5. DATE OF BIRTH<br><b>Apr. 2, 1898</b>  |  | 6. AGE (IN YEARS-LAST BIRTHDAY)<br><b>88</b>   |               | 7. UNDER 1 YEAR<br>MONTHS DAYS  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sicily</b>  | 9. CITIZEN OF WHAT COUNTRY?<br><b>Sicily</b> | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, Md</b>   |               |   |
| 12. CITY OR TOWN OF DEATH<br><b>Parkville</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Perring Parkway Nursing Home</b>   |  | 14. USUAL OCCUPATION (TYPE OF WORK) (RE)<br><b>Housewife</b>   |               | 15. KIND OF BUSINESS OR INDUSTRY  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE <b>Maryland</b> 12b. COUNTY <b>Baltimore</b> 12c. CITY OR TOWN <b>Parkville</b>  |  |  |  |  |               |   |
| 17. FATHER'S NAME<br>(TYPE OR PRINT)<br><b>Guiseppi Mirabile</b>   |  | 18. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)<br><b>Vennera Quattrocchi</b>  |  |  |               |   |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 19b. SOCIAL SECURITY NO.<br><b>220-24-5262</b>   |  | 20. INFORMANT<br><b>Mr. John R. Scilipote Sr.</b><br>ADDRESS<br><b>2925 Cub Hill Rd. 21234</b>   |               |   |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy - Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic passive congestive - hepatic metastatic malignancy</b> |  |  |  |  |               | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (WHICH CAME FIRST)   |  |  |  |  |               |   |
| 23a. DATE OF OPERATION   |  | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 24. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |               | 25. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)   |  | 26b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Aug. 19 58</b>   |  | 26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |               | 26d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |
| 27a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 27b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 27c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>9005 Harford Rd. Baltimore Md 21234</b>  |               | 27d. DATE SIGNED<br><b>7/8/86</b>   |
| 27e. I certify that (1) (this hospital) attended the deceased from <b>Aug. 19 58</b> to <b>July 86</b> ; that (1) (the) last saw the deceased alive on <b>7/7/86</b> and that in my (my) opinion death occurred on the date and hour and from the causes stated above; (2) (the body) was released to the body of the death.   |  |  |  |  |               |   |
| 27f. SIGNATURE<br><b>Frank T. Kasik</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |               | 27g. DATE SIGNED<br><b>7/8/86</b>   |
| 27h. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frank T. Kasik</b>   |  | 27i. ADDRESS<br><b>9005 Harford Rd. Baltimore Md 21234</b>   |  |  |               |   |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 28b. DATE<br><b>7/11/1986</b>  |  | 28c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>   |               | 28d. LOCATION<br><b>Baltimore, Md.</b> STATE  |
| 29. FUNERAL DIRECTOR<br><b>Leonard J. Ruok Inc Baltimore, Md.</b>  |  |  |  | 30. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1986</b>   |               |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 28, attach any injury or other traumatic event, the medical certificate, with the certificate of death.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19029

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY W. SCOTT</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 29, 1986</b>   |  | 2b. HOUR<br>M                                |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 17, 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b><br>YRS MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO.</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TIMONIUM</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2211 EAST RIDGE RD. 21093</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO. CO.</b> 13c. CITY OR TOWN  |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE<br><b>2211 EAST RIDGE RD. 21093</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HUBERT E. WARNER</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE BROWN</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>220-38-566</b>   |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                     |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 21<sup>st</sup></b> , 19 <b>83</b> , to <b>July 29<sup>th</sup></b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>June 19<sup>th</sup></b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Kevin Quinn MD</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>7/31/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. KEVIN QUINN</b>  |   | 22e. ADDRESS<br><b>1205 YORK RD, TOWSON</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>AUG. 1, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>COXESBURG U.M. CHURCH</b>             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ABINGDON, HARTFORD CO. MD.</b>  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>EVANS CHAPEL OF CHIMES</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 7 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                    |  |



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Henry Clement Scout</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 - 29 - 86</b>                        |   | 2b HOUR<br>M<br><b></b>                           |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 - 25 - 08</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Phoenix</b>  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3219 Paper Mill Road</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b> |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Lumber</b> |
| 13a STATE<br><b>Maryland</b>  |   | 13b COUNTY<br><b>Baltimore</b>   | 13c CITY OR TOWN<br><b>Phoenix</b>  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b></b>  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b></b>                         |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b SOCIAL SECURITY NO.<br><b>-</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Elizabeth Tarin 5285 S. Yampa St.<br/>Aurora, Colorado 80015</b> |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Lung Cancer</b> |   |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |  |   |   |   |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b></b> P.M. <b>19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                       |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)  |   |  |   |   |   |
| 22b SIGNATURE<br><b>Paul M. Rivas</b>   |   | DEGREE<br><b>MD</b>  |   | 22c DATE SIGNED<br><b>7-30-86</b>   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul M. Rivas</b>  |   | 22e ADDRESS<br><b>3421 Sweet Air Rd.</b>   |   |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b DATE<br><b>7-31-86</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Clynmalira Meth. Cem.</b>                                   |   |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Phoenix Balto. Md.</b>  |   | 23e DATE REC'D. BY REGISTRAR<br><b>AUG 1 1986</b>  |   |   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Bryan W. Clary</b>  |   | ADDRESS<br><b>10 W. Padonia Rd 21093</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b></b>  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed and filed with the State Dept. of Health and Mental Hygiene.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                     |   |   |  |  |  |                      | REG. NO. 876 19034   |  |
|--|--|---|---------------------|---|---|--|--|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |   |                     |   |   |  |  |  |                      |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>LINDA H. SCOVILL  |  |   |                     |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 2, 1986   |  |  | 2b. HOUR a<br>4:00 M |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 16, 1943  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                      | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Co.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8407 Green Spring Avenue |                     |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |                      |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |                     |   |   | 12208  |  |  |                      |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Balto.   |                     | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>8407 Green Spring Avenue                           |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert Hammond  |  |   |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy Swartz   |   |  |  |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 42 2102  |   | 17. INFORMANT<br>ADDRESS<br>Dr. William A. Scovill, Same   |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS  |  |   |                     |   |   |  |  |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) ADVANCED MULTIPLE SCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |                     |   |   |  |  |  |                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a   |  |   |                     |   |   |  |  |  |                      |  |  |
| 19a. DATE OF OPERATION   |  |   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                      |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from July 19 80, to July 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |                     |   |   |  |  |  |                      |  |  |
| 22b. SIGNATURE<br>Howard Weiss MD  |  |   |                     |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7-2-86   |                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Howard Weiss MD   |  |   |                     |   |   | 22e. ADDRESS<br>2435 W. Belvedere 21215  |  |  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |   | 23b. DATE<br>7/3/86 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD                             |                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |   |                     |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 3 1986 [Signature]   |  |  |                      |  |  |



00-11925

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Rita Veronica Seavey</b>   |  |   |  |   |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 4 06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                              |  | 2b. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>7-3-86 6P M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Julie Infirmary</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nun</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Religious Order</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Fred Seavey</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emily Keene</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>188-42-0313</b>  |  | 17. INFORMANT ADDRESS<br><b>Sister Kathleen O'Brien Same as 13e</b>            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>with organic brain syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory failure</b> |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>1153</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-11-36</b> 19 <b>86</b> , to <b>7-3-86</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>6-11-36</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Prahima Bose MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PRAHIMA BOSE MD</b>   |  |   |  | 22e. ADDRESS<br><b>301 St. Paul Place Baltimore MD 21201</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/7/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ilchester Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ilchester Howard Md.</b>      |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |   |  | ADDRESS<br><b>1050 York Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 7 1986</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

[illegible]

4518

McLaren, Inc., 100 York St.

0-14130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

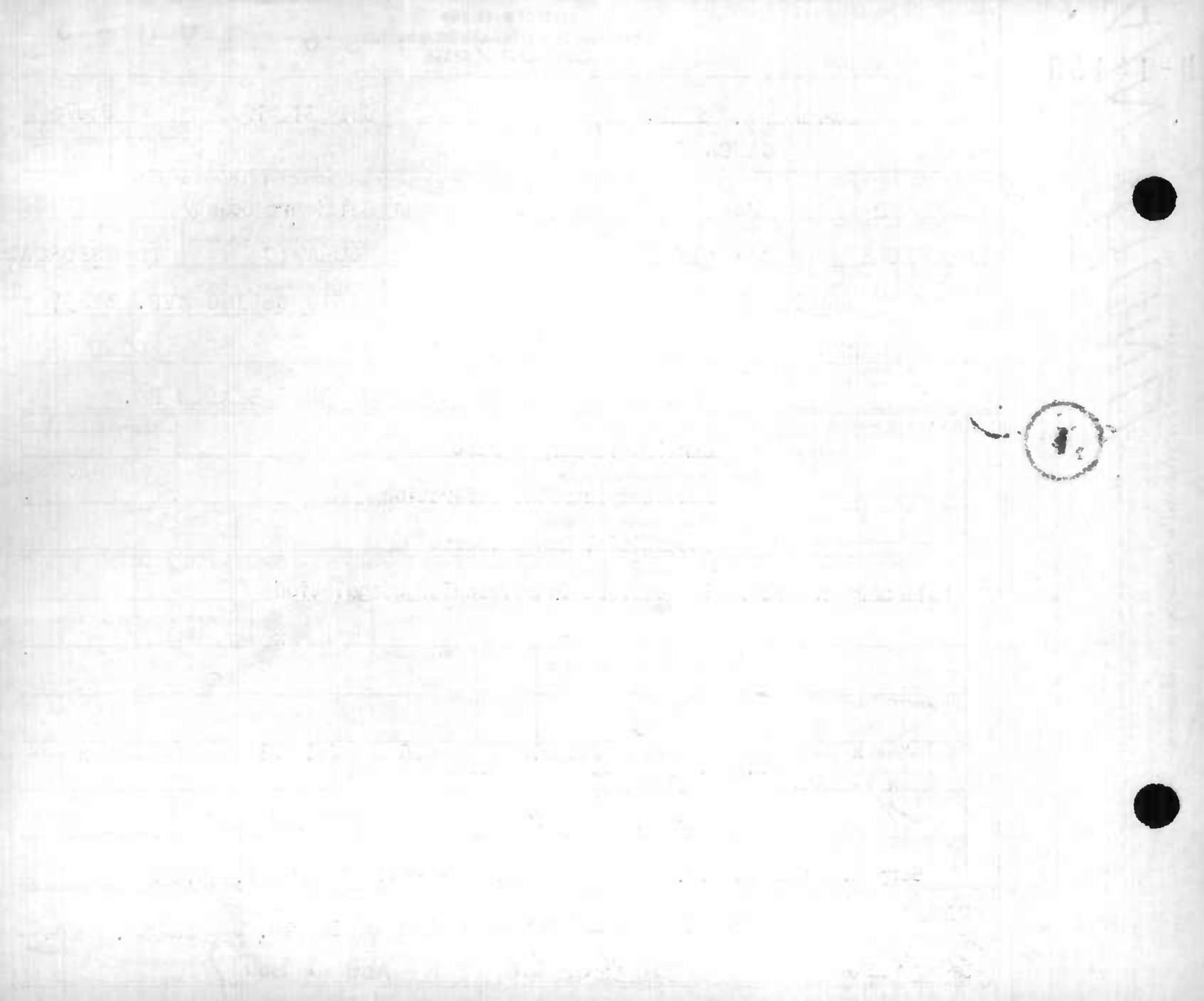
8 6 1 9 0 3 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                            |   |   |
|--|--|--|---|---|----------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lawrence C. SELING</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 31, 1986</b> |   | 2b. HOUR<br><b>3:07a M</b> |   |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 03 08</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANIC</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRANSPORTATION</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 13d. STREET ADDRESS / ZIP CODE<br><b>1510 SELING AVE. 21237</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FREDERICK SELING</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY FOGEL</b>   |   |   |                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216010349</b>   |   | 17. INFORMANT ADDRESS<br><b>JERRY SELING 13408 BLADON RD.</b>   |                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Recent Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Intestinal Lung Disease</b>  |  |  |   |   |                            |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Pulmonary Tuberculosis, Diffuse Intravascular Coagulation</b>   |  |  |   |   |                            |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 17</b> , 19 <b>86</b> , to <b>July 31</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>July 31</b> , 19 <b>86</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |   |                            |   |   |
| 22b. SIGNATURE<br><i>Gary A. Johnson</i>   |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>7-31-86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary A. Johnson, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |   |   |                            |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>08/02</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>gardens of Faith</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Balto md</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John E. Smith</i>   |  | ADDRESS<br><i>1201 Chesapeake Ave</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 1 1986</b>  |                            | 25b. REGISTRAR'S SIGNATURE<br><i>John E. Smith</i>  |   |

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-14041

|   |  |  |   |  |   |  |   |   |  |
|---|--|--|---|--|---|--|---|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |  |   |   |  |
| 1- FOR STATE REGISTRAR  |  |  |   |  |   |  |   |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDGAR EUGENE SHAFFER SR.   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>July 30, 1986 |  |   | 2b HOUR<br>11 A.M.   |   |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 15, 1900   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>972 St. Agnes Lane |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer                    |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Construction          |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>Baltimore  |   | 13c CITY OR TOWN<br>Baltimore  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS / ZIP CODE<br>972 St. Agnes Lane 21207 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Albert Shaffer   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Elizabeth Ward   |   |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-05-2524  |   | 17 INFORMANT<br>ADDRESS<br>Evelyn Jean Shaffer Same as # 13  |   |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic CVD, advanced</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u> |  |  |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Alzheimer's Syndrome</u>   |  |  |   |  |   |  |   |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>86</u> , to <u>7/30</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>7/29</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death.   |  |  |   |  |   |  |   |   |  |
| 22b SIGNATURE<br><u>Herbert J. Levickas, M.D.</u>   |  |  |   | DEGREE<br>M.D.   |   |  |   | 22c DATE SIGNED<br>7/31/86                                |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Herbert J. Levickas   |  |  |   | 22e ADDRESS<br>5404 East Drive Baltimore, Maryland   |   |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>8/2/86   |   | 23c NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Maryland                                 |   |   |  |
| 24 FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228   |  |  |   | 25a DATE REC'D. BY REGISTRAR<br>JUL 31 1986  |   | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11/11/00 BY SP-6 JAC/STP



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19035

REG. NO.

|   |  |  |  |   |                                      |
|---|--|--|--|---|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Emma Sherrod</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7-25-86</b> |   | 2b. HOUR<br><b>6<sup>05</sup> AM</b> |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 18 44</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS<br><b>42 YRS</b> MONTHS DAYS HOURS MIN. |                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>n.c.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County MD.</b>  |                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b>                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER FACILITY, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN<br><b>md. Landover 20785</b> |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>Landover md 20785 2116 Columbie Ph.</b>                            |                                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harry Sherrod</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Staton</b>  |  |   |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |                                      |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cancer of Parathyroid**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (this hospital) attended the deceased from <b>7/21</b> 19 <b>86</b> to <b>7/25</b> 19 <b>86</b> that (I) (we) lost<br>saw the deceased alive on <b>7/25</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>K R Faulkner MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>7/25/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall R. Faulkner, M.D.</b>  |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>Dulaney Valley Rd.-Towson, MD 21204</b> |  |  |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>July 30</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Landover PG Md</b> |
| 24. FUNERAL DIRECTOR NAME<br><b>J.B. Jenkins FH</b>        |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 29 1986</b>  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Landover, Md 7474</b>   |                             | 25b. REGISTRAR'S SIGNATURE                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and complies with the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-13859

OK Flinders

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19036

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(Type or Print) <b>(Sister) Mary Catherine of Sienna Siebenhaar</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7/09/86</b>   |  | 2b. HOUR<br><b>4:45P</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 18, 1893</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore County</b> MD.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Assumpta, 6401 N. Charles</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Cook</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>6401 N. Charles St. 21212</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Burkhard Siebenhaar</b> <del>Burkhard</del>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Hein</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-54-7749</b>   | 17. INFORMANT<br>ADDRESS<br><b>Jr S. Angelina, same</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Age</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Age</b>      |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>78</b> , to <b>July</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>July 09</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Lawrence Boas</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>7/10/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Lawrence Boas, M. D.</b>  |   | 22e. ADDRESS<br><b>54 Scott Adam Rd., Cockeysville, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>7-12-86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Villa Maria Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Arm, Balto., Md.</b>           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>  |   | ADDRESS<br><b>6500 York Road 21212</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 14 1986</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Andrew Updegrave</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

$$-\int_{\mathbb{R}^n} \nabla \cdot \mathbf{u} \, dx = 0$$

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86-19037

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 7/10/86  |  | 7 10 86 430 P.M.  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE   |  | WHITE  |  | MONTH DAY YEAR   |  | 71 YRS  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MARYLAND   |  | USA  |  |  |  | BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                             |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE RANDALLSTOWN   |  | BALTIMORE COUNTY GENERAL   |  | Salesperson  |  | Sales   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS   |  |
| MD   |  | BALT.  |  | RANDALLSTOWN MD  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  |
| ISRAEL   |  | BESSIE GILBERG   |  | NO   |  | 212-01-3405   |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| MRS. JAE ZALIS   |  | PART 1. DEATH WAS CAUSED BY:   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 4002 McDONOGH RD. RANDALLSTOWN, MD 21133   |  | IMMEDIATE CAUSE (a) Hepato renal failure   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY   |  |
|  |  | (b) Hepatic metastases   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY  |  |
|  |  | (c) Gastric Ca.  |  | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.                        |  |
|  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a |  | 21f. LOCATION  |  | CITY OR TOWN COUNTY STATE   |  |
|  |  |  |  | BALTO. CO. GEN. HOSP. - RANDALLSTOWN, MD   |  |   |  |
| 22a. SIGNATURE   |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22c. DATE SIGNED   |  | 22d. ADDRESS  |  |
| m. ELNOUR  |  | M. ELNOUR  |  | 7/11/86  |  | BALTO. CO. GEN. HOSP. - RANDALLSTOWN, MD                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| BURIAL   |  | JULY 13, 1986  |  | TIFERETH ISRAEL  |  | ROSEDALE BALTO. MD  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| SOL LEVINSON & BROS., INC.   |  | JUL 16 1986  |  | Julia Davidson-Henderson   |  |   |  |
| NAME   |  | ADDRESS  |  | CITY OR TOWN   |  | STATE   |  |
| 2016 REISTERSTOWN RD.  |  | BALTO., MD 21215   |  | BALTO.   |  | MD  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86-19038  
REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST Elizabeth Lillian<br>MIDDLE A<br>LAST SINDALL   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>07 19 86  |  | 2b. HOUR<br>2:00A M   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUC. White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 25 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, COUNTY MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Buyer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST Vernon MIDDLE M. LAST Sindall                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE B. LAST Bavis   |  | 13e. STREET ADDRESS / ZIP CODE<br>3010 White Ave. 21214   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-12-6398  |  | 17. INFORMANT<br>Gregory C. Nelson, 5003 Greenhill Ave.   |  | ADDRESS<br>21206  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) METATSTATIC BREAST CA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from 5/25 19 86, to 7/19 19 86, that (I) (we) last saw the deceased alive on 7/18 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Shohreh Taavoni   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>7/19/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Shohreh Taavoni  |  | 22e. ADDRESS<br>GBMC   |  |  |  |   |  |

|  |  |                      |  |  |  |   |  |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                       |  | 23b. DATE<br>7-21-86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME Leonard J. Ruck, Inc., 5305 Harford Rd. ADDRESS |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 21 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-13391

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

19039

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Milton J Siney  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-23-86  |   | 2b. HOUR<br>2:09pm  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 30 08   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>77 YRS   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, County MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Towson, Maryland  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Joseph Hospital |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Painter Ret.   |   |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1427 Putty Hill Ave. 21204  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Siney   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Trenkamp  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Army WW II 215-07-9987  | 17. INFORMANT ADDRESS<br>Maria S. Mehling 1427 Putty Hill Ave. 21204   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial infarction  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 days |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-<br>Cardiogenic shock   |  |  |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from July 20, 1986, to July 22, 1986, that (I) (we) lost<br>saw the deceased alive on July 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |   |   |
| 22b. SIGNATURE<br>Samuel L O'Malley  |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>July 22 1986  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL O'MALLEY   |  | 22e. ADDRESS<br>8405A LOU RAVEN BLVD BALTO MD.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Jul 25 1986   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.  |  |  | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE<br>JUL 24 1986                           |   |   |

Abstract 100

12345

000-11985

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86-19040

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Evelyn H. Simpson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 8 86</b>  |   | 2b. HOUR<br><b>1:00</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cost Clerk</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>S.S. Office</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>524 N. Charles St. Balto. Md. 21201</b>                        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Headley</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Miller</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-12-6156</b>  |   | 17. INFORMANT<br><b>Arlington, Va. 22203</b><br><b>Miss Margaret S. Simpson, 905 N. Pollard St.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Ca</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>April 7 19 86</b><br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 7 19 86</b> , to <b>July 8 19 86</b> , that (I) (we) last saw the deceased alive on <b>July 7 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Dr. Eddie Nakhuda</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>2300 Dulaney Valley Road Towson, Md. 21204</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/10/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemt.</b>                                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>  |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Rendall</b>   |   |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked either 18, 19, 20, or 21, the medical examiner must be notified at once.

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Handwritten notes and stamps, including "100-100" and "100-100".



100-100

Handwritten notes and stamps, including "100-100" and "100-100".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 4 1

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara — SIPPET   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-15-86  |  | 2b. HOUR<br>9:10 P.M.  |  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 9 02   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Heritage Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Housewife                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |  |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>BowleysQuarters  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>3908 New Section Road 21220                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emil Ruzicka  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Mach   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-18-5445   | 17. INFORMANT<br>ADDRESS<br>Kathleen Cox 7840 Eastdale Road 21224   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRAL INFARCTION.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HYPERTENSION -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ASPIRATION PNEUMONIA.   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/22/1986 to 7/15/1986 that (I) (we) lost<br>saw the deceased alive on 7/15/1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>K. J. HARMASENA   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   |  | 22c. DATE SIGNED<br>7/16/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. J. HARMASENA  |  | 22e. ADDRESS<br># 8, 16th AVE. BALT. Md 21225   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>7/19/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Bohemian National                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connolly Funeral Home   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 22 1986   |  | 25b. REGISTRAR'S SIGNATURE                                       |
| ADDRESS<br>300 Mace Ave 21221   |  |   |   |  |  |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19042  
REG. NO.

|   |   |   |  |   |  |   |                                   |   |
|---|---|---|--|---|--|---|-----------------------------------|---|
| 1. FOR STATE REGISTRAR  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR  |                                   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ruth H. SKIDMORE  |   |   | July 13, 1986  |   |  | 10:01P <sub>M</sub>   |                                   |   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MARCH 24, 1909   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS  |   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                      |                                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County . MD.   |   |  |   |                                   |   |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSP. |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MALE, DOMESTIC TYPE)<br>HOMEMAKER |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>W. VA. BRAXTON CORLEY  |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  | 13e. STREET ADDRESS / ZIP CODE<br>RT #6 BOX 17 926616                             |                                   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WALTER LEE HOPKINS   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CARRIE J. DETAMORE   |   |  |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   |   | 16b. SOCIAL SECURITY NO.<br>235-62-0342  |   |  | 17. INFORMANT ADDRESS<br>Wayne Hopkins 20 ARMOR CT. BALTO. MD. 21220              |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Possible Ruptured Aneurysm<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |   |  |   |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |   |   |  |   |  |   |                                   |   |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)    |                                   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                   |   |
| 22a. I certify that I (this hospital) attended the deceased from July 13, 1986, to July 13, 1986, that I (we) last saw the deceased alive on July 13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death.)   |   |   |  |   |  |   |                                   |   |
| 22b. SIGNATURE<br>Dan K. Morhaim, M.D.  |   |   | 22c. DATE SIGNED   |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dan K. Morhaim, M.D.                     |                                   |   |
| 22e. ADDRESS<br>9000 Franklin Square Drive - 21237  |   |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22g. DATE SIGNED  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (BY)<br>BURIAL  |   |   | 23b. DATE<br>7-17-86   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. HEBRON CEM.                             |                                   |   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SUTTON U. VA.  |   |   | 24. FUNERAL DIRECTOR<br>Capitol Funeral Ser. Falls Church VA.  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1986                                      |                                   |   |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |   |   |  |   |  |   |                                   |   |

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Don K. Robinson, M.D.

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00-13783

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19043  
REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Viola Elizabeth SKILLMAN   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 25, 1986   |  | 2b. HOUR<br>2:30A/ M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 26, 1905  |  |
| 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  | 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker   |  | 13a. STREET ADDRESS / ZIP CODE<br>3923 E. Baker Ave 21009  |  |   |  |
| 13b. COUNTY<br>Harford   |  | 13c. TOWN<br>Abingdon  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Thomas Wynkoop   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace LLOYD   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>ADDRESS<br>Joseph A. Skillman 3923 E. Baker Ave.<br>Abingdon, Md. 21009        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Chronic renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Peri-cecal abcess; Diverticular disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 8,</u> 19 <u>86</u> , to <u>July 25,</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>July 25,</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br>Sarah L. Owens   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>7/25/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sarah L. Owens, M.D.  |  | 22e. ADDRESS<br>9000 Franklin Square Drive - 21237   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-28-86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Memorial  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford Md.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas III 1317 Cokesbury Rd.<br>Abingdon, Md. 21009  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JUL 29 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>L. Davidson  |  |   |  |

MEDICAL CERTIFICATION

86-13783

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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NO 83 10

800-13936

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19044

REG. NO.

|  |  |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles William Skinner   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 20 86  |   |   | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 16 12   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Nebraska  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Fullerton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4609 Ridgeway Avenue 21206 |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret.-Elec.Const. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>B.G.& E.  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST William MIDDLE W. LAST Skinner  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Anna MIDDLE H. LAST Fegan   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) Yes             |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR DATES) 1930-33 185-03-4626   |  |   | 17. INFORMANT ADDRESS<br>21093 William W. Skinner P.O.Box 68 Lutherville, Md.   |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u> |  |   |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Isolate Medulla</u>  |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR (CONTRIBUTING) CAUSE OF DEATH <input type="checkbox"/><br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> 19 <u>86</u> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                               |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>W.K. Wong</u>   |  |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22d. DATE SIGNED   |   |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wyman K. Wong, M.D. (665-7677)  |  |   | 22f. ADDRESS<br>6801 Belair Rd. Baltimore, Md. 21206  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |  |   | 23b. DATE<br>7-24-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Pk. Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  |   | ADDRESS<br>1401 Belair Rd. BALTO. MD. 21236   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1986   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson Radner  |  |   |   |   |   |  |   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-11336

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Joseph Smolko  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 1, 1986                        |   | 2b. HOUR<br>P.<br>M.   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 6 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>8. UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Eastwood  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7119 Gough Street 21224 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Amer. Smelting              |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Eastwood  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>John Middle Andrew Last Smolko  |  | 15. MOTHER'S MAIDEN NAME<br>Catherine Middle Last   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-10-1635  |  | 17. INFORMANT<br>ADDRESS<br>Evelyn J. Smolko 7119 Gough St. 21224                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease and</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal Failure, Depression</u>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/31/85</u> to <u>7/1/86</u> , that (I) <u>was</u> last saw the deceased alive on <u>6/29/86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>DH Sherbourne</u>   |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>7/3/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SHERBOURNE</u>   |  | 22e. ADDRESS<br><u>9101 Frutkin Sq Dr Balto 21237</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>7-05-86</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sacred Heart of Jesus</u>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Dundalk, Balto. Co., Md.</u>  |  | 23e. DATE REC'D. BY REGISTRAR<br><u>JUL 3 1986</u>  |  | 23f. REGISTRAR'S SIGNATURE<br><u>Jane Anderson-Hendell</u>                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Charles S. Zeiler &amp; Son Inc.</u> ADDRESS<br><u>6224 Eastern Ave.</u>  |  |   |  |   |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who has caused a death.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR<br>Robert J. Sneeringer Sr.   |  |   |  |   | 8 6 1 9 0 4 6<br>REG. NO.  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Robert SNEERINGER  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 4, 1986                 |   |  | 2b. HOUR<br>9:15A M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 20, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Co.   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2346 Martin Dr. 21221  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert T. Sneeringer   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie A. Divine |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>Ada Sneeringer (wife)  |  | ADDRESS<br>(Same)   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest secondary to multisystem failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Myocardial infarction and cardiogenic shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Transitional cell carcinoma of the bladder   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from June 11, 1986, to July 4, 1986, that (we) last saw the deceased alive on July 4, 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Carol Herbert MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>7-4-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carol Herbert, MD   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/7/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County Maryland                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave.  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>JUL 8 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

MEDICAL CERTIFICATION

November 20, 1960

Mr. [illegible]

Dear Sir:

[illegible]

[illegible]

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,

[illegible]

[illegible]

[illegible]

[illegible]

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00-12051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. It should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, MD medical investigation may be conducted.

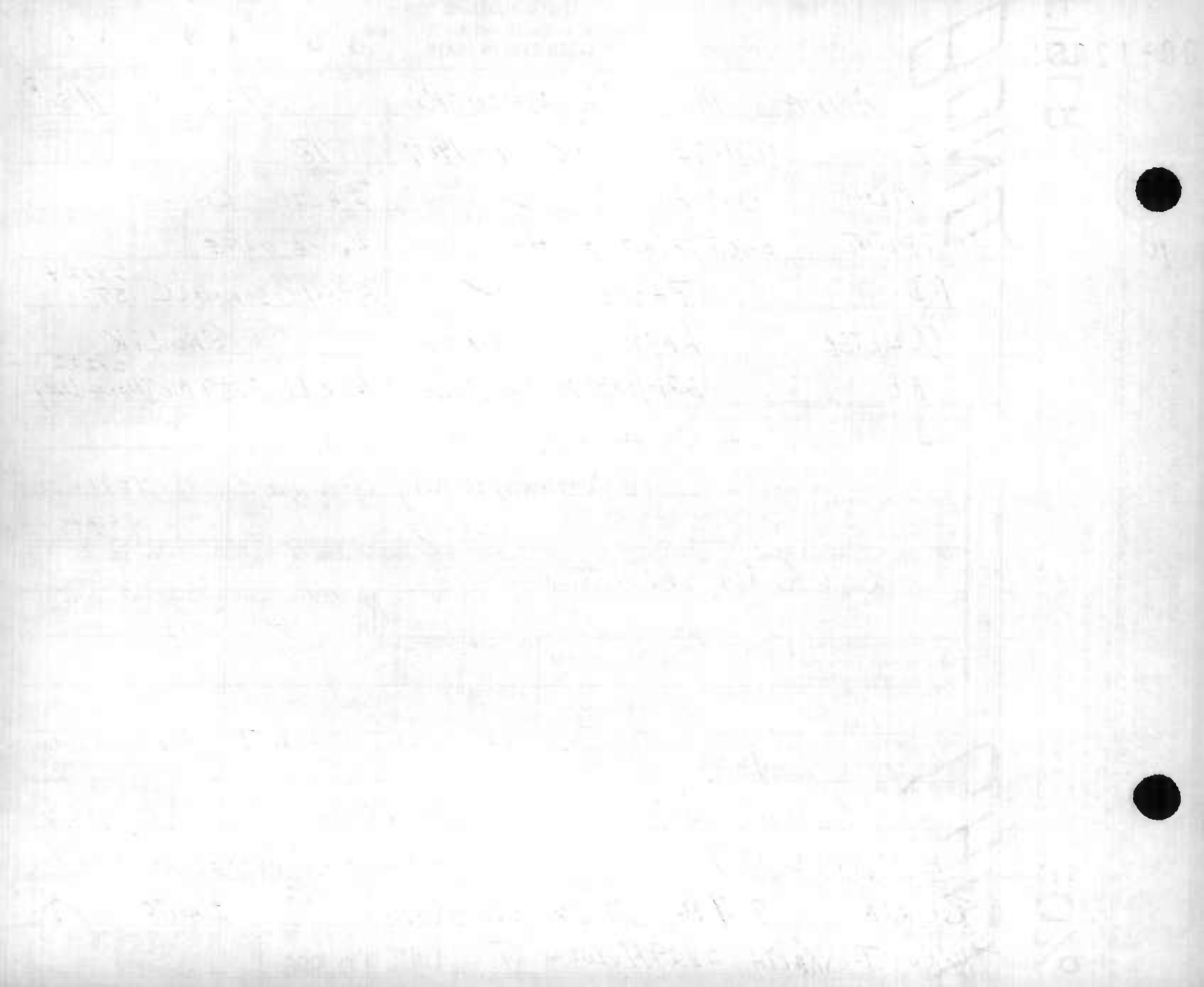
1- FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8619047

REG. NO.

|  |  |   |   |  |   |  |  |   |  |   |  |
|--|--|---|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. SNIADOWSKI</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>7-7-86</b>                      |  |   | 2b. HOUR <b>11:30 P.M.</b>   |  |   |  |   |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>8-1-1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.   |  | 7. UNDER 1 YEAR MONTHS DAYS <b>11</b> HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO. MD.</b>   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>EASTPOINT</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTPOINT N. H.</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE <b>MD.</b>  |  |   | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>BALTO.</b>                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <b>2904 O'DONNELL ST. 21224</b> |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>WALTER LAYKO ANNA GAWLIK</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>ANNA GAWLIK</b>  |   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>221-18-3895</b> |  |
| 17. INFORMANT ADDRESS <b>CHARLOTTE SHEERILL 3559 McSHANE WAY 21222</b>   |  |   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b> |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |   | (b) <b>Coronary artery disease</b>   |   |  |  | years   |  |   |  |
|  |  |   |   | (c) <b>ASPRVD</b>  |   |  |  | years   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>slight cellulitis</b>  |  |   |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 12</b> , 19 <b>86</b> , to <b>July 7</b> , 19 <b>86</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>July 3</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE <b>B. MATOS, M.D.</b>   |  |   | DEGREE  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>7/9/86</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. MATOS, M.D.</b>  |  |   | 22e. ADDRESS <b>21 PRANBROOK RD COLLETSVILLE MD 21030</b>           |  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  |   | 23b. DATE <b>7-11-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>                                    |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>THOMAS J. SKALDA 2829 HUDSON ST.</b>  |  |   |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

BP



7  
00-12864STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19048  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ruth E SOPEL  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 14, 1986   |  | 2b. HOUR<br>5:15 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 8 1914   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 11. CITY OR TOWN OF DEATH<br>Balto.  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp.                       |  | 13. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Clerk  |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br>Md.   |  | 14b. COUNTY<br>BALTO   |  | 14c. CITY OR TOWN<br>Balto.   |  |
| 15. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 16. STREET ADDRESS / ZIP CODE<br>3101 Four Seasons Ct. 21222   |  | 17. MOTHER'S MAIDEN NAME<br>Douglas Northrup  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herman Davis   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Douglas Northrup  |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |
| 21. SOCIAL SECURITY NO.<br>220-24-3582   |  | 22. INFORMANT<br>32 ADDRESS Patapsco Ave.<br>Ms. Lucy Sopel Balto., Md.  |  | 23. CAUSE OF DEATH (Enter only one cause per part)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <del>ADENOCARCINOMA OF THE LEFT LUNG</del><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>EMPHYSEMA  |  |  |  |   |  |
| 24. DATE OF OPERATION  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 30. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 33. I certify that (this hospital) attended the deceased from JULY 11, 1986, to JULY 14, 1986, that (we) last saw the deceased alive on JULY 14, 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |  |  |  |   |  |
| 34. SIGNATURE<br>IOANNA GOUNI Md.,   |  | 35. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 36. DATE SIGNED<br>JULY 14, 1986  |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ioanna Gouni   |  | 38. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 40. DATE<br>7-15-86  |  | 41. NAME OF CEMETERY OR CREMATORY   |  |
| 42. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  | 43. ADDRESS<br>Balto., Md.   |  | 44. DATE REC'D. BY REGISTRAR<br>JUL 18 1986   |  |
| 45. REGISTRAR'S SIGNATURE<br>Julia Gordon-Rudner   |  | 46. REGISTRAR'S SIGNATURE  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director's page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



00-11860

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

19049

|  |                               |   |   |  |  |  |                                   |   |                 |   |      |
|--|-------------------------------|---|---|--|--|--|-----------------------------------|---|-----------------|---|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                               | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH  |  | MONTH                             | DAY   | YEAR            | 2b. HOUR  |      |
| William Euler Spehnkouch   |                               |   |   |  | July 8, 1986   |  |                                   |   |                 | 9-15 A  |      |
| 3. SEX   | 4. RACE                       | 5. DATE OF BIRTH  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR                   |   | IF UNDER 24 HRS |   |      |
| Male   | White                         | 7-25-21   |   |  | 64   |  | MONTHS                            |   | DAYS            |   | MIN. |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OR NATAL COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |   |                 |   |      |
| Maryland   | USA                           |   |   |  | Baltimore County   |  |                                   |   | MD.             |   |      |
| 10. CITY OR TOWN OF DEATH  |                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                 |   |      |
| Randallstown   |                               | Baltimore County General Hospital   |   |  | Retired  |  | Westinghouse                      |   |                 |   |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                               |   |   |  |  |  |                                   |   |                 |   |      |
| 13a. STATE   | 13b. COUNTY                   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE   |  |  |                                   |   |                 |   |      |
| Maryland   | Baltimore                     | Rockdale  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 3710 Wildor Ave.   |  | 21207  |                                   |   |                 |   |      |
| 14. FATHER'S NAME  |                               |   |   | 15. MOTHER'S MAIDEN NAME   |  |  |                                   |   |                 |   |      |
| FIRST MIDDLE LAST<br>William Spehnkouch  |                               |   |   | FIRST MIDDLE LAST<br>Margaret Euler                                    |  |  |                                   |   |                 |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                               |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |  | 17. INFORMANT ADDRESS  |                                   |   |                 |   |      |
| Yes  |                               |   |   | WW 2   |  | Baltimore MD. 21207<br>Mrs. Carol Spehnkouch 3710 Wildor Ave.                  |                                   |   |                 |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |                               |   |   |  |  |  |                                   |   |                 |   |      |
| PART I. DEATH WAS CAUSED BY:   |                               |   |   |  |  |  |                                   |   |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |      |
| IMMEDIATE CAUSE (a) S/P CARDIO PULMONARY ARREST  |                               |   |   |  |  |  |                                   |   |                 |   |      |
| DUE TO, OR AS A CONSEQUENCE OF (b) S/P MYOCARDIAL INFARCTION   |                               |   |   |  |  |  |                                   |   |                 |   |      |
| DUE TO, OR AS A CONSEQUENCE OF (c) S/P VENTRICULAR FIBRILLATION  |                               |   |   |  |  |  |                                   |   |                 |   |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |                               |   |   |  |  |  |                                   |   |                 |   |      |
| 19a. DATE OF OPERATION   |                               |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |                                   | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |      |
|  |                               |   |   |  |  |  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>          |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |   |                 |   |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                               |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET  |                                   | CITY OR TOWN  |                 | COUNTY STATE  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/6/86 to 7/8/86, that (I) (we) last saw the deceased alive on 7/8/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                               |   |   |  |  |  |                                   |   |                 |   |      |
| 22b. SIGNATURE<br>Ambachew Woreta MD   |                               |   |   |  |  |  |                                   | 22c. DATE SIGNED  |                 |   |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                               |   |   | 22e. ADDRESS   |  |  |                                   |   |                 |   |      |
| AMBACHEW WORETA  |                               |   |   | 9233 WINDING WAY, ELLICOTT CITY, MD 21044                              |  |  |                                   |   |                 |   |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                               |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                 |   |      |
| Burial   |                               |   |   | 7-11-86  |  | Loudon Park Cemetery   |                                   | Baltimore City MD   |                 |   |      |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc<br>8728 Liberty Rd. Randallstown, MD 21133  |                               |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE  |                 |   |      |
|  |                               |   |   |  |  | JUL 9 1986   |                                   | John Davidson-Randall   |                 |   |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other significant condition, the medical examiner should be notified.

1965 COLLECTA 1965

1965 COLLECTA 1965

1

1965 COLLECTA 1965

00-12202

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 0 5 0

|  |  |   |  |  |                     |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---------------------|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNA ELIZABETH SPINE  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>7 08 '86 |  | 2b. HOUR<br>7:00P M |   |  |  |   |  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 12, 1915  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.            |  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>GBMC-6701 N. CHARLES ST. |  |  |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tele. Operator              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Answering Serv.      |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore  |  |   |  |  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br>6209 Brook Avenue 21206 |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Julius Marecki  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Lisek   |                     |   |  | 16. ADDRESS<br>Baltimore, MD.  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-22-6090              |  | 17. INFORMANT<br>Julia S Raab 7902 Ardmore Avenue 21234  |                     |   |  | ADDRESS Baltimore, MD.   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY EMBOLUS, PROBABLE<br>DUE TO, OR AS A CONSEQUENCE OF (b) CHF<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |                     |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |                     |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  |  |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                     |   |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                     |   |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/02, 19 86, to 7/08, 19 86, that (I) (we) lost<br>saw the deceased alive on 7/08, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) sign the body after death. |  |   |  |  |                     |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>ARTHUR SMITH, M.D.   |  |   |  | DEGREE<br>MEDICAL PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |                     |   |  | 22c. DATE SIGNED<br>7/8/86   |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR SMITH, M.D.  |  |   |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES ST.   |                     |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>07/11/1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem   |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. M.d                                 |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Home Inc.<br>7110 Belair Road Baltimore MD 21206  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1986   |                     |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia S Raab |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

10-15303

THE UNIVERSITY OF

ANTHONY, NEW YORK

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

19051

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |                          |  |
|---|--|---|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ETHEL STANCHFIELD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 18 86</b> |  | 2b. HOUR<br><b>18.15</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 20, 1907</b>   |                          |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | 8. IF UNDER 24 HRS.  |                          |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maine</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Person-Retail Dept. Store</b> |                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>   |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel McGlynn</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel Faulkner</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>069-28-2000</b>   |   | 17. INFORMANT<br><b>Mr. Bruce Stanchfield</b> 20877<br><b>264 West Deer Park Road Gaithersburg, MD.</b>    |                          |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Lung Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>b) <b>CO PD.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CO PD.</b>  |  |   |   |  |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                             |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6. 29 19 86</b> to <b>7. 18 86</b> , that (I) (we) last saw the deceased alive on <b>7. 18 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |                          |  |
| 22b. SIGNATURE<br><b>RAYADURG GOVINDA</b>   |  | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>7.18.86</b>   |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>BALT COUNTY GNL HOSPITAL</b>   |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 21, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brookland Mem. Park</b>   |                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Portland Cumberland Maine</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, MD. 21133</b>               |   |  |                          |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><b>JUL 23 1986</b>  |   |  |                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 about any injury, or other traumatic event, the medical examiner must be notified of this.



CHILMIL

100% COTTON L. BER

00-12672

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH8 6  
1 9 0 5 2  
REG. NO.

|  |  |         |                   |  |  |   |  |   |   |  |  |   |  |            |  |
|--|--|---------|-------------------|--|--|---|--|---|---|--|--|---|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST |  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |  |   | MONTH DAY YEAR  |  |  | 2b. HOUR  |  |            |  |
| FRANCIS D. STEEDMAN  |  |         |                   |  |  | X   |  |   | 7 13 86   |  |  | M   |  |            |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)                         |  | IF UNDER 1 YR.  |   | IF UNDER 24 HRS.                           |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | 2d. HOUR   |  |
| Male   |  | White   |                   | Oct. 2, 1940   |  | 45 YRS.                                   |  |   |   |  |  | 7 13 86   |  | 5:39 P. M. |  |
| 7. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |            |  |
| Maryland   |  |         |                   | U.S.A.   |  |   |  |   |   |  |  | Baltimore County, MD.   |  |            |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |   |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |            |  |
| Towson   |  |         |                   | St. Joseph's Hospital  |  |   |  | Salesman  |   |  |  |   |  |            |  |
| 13a. STATE   |  |         | 13b. COUNTY       |  |  | 13c. CITY OR TOWN                         |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS   |  |            |  |
| Maryland   |  |         | Baltimore         |  |  | Towson                                    |  |   |   |  |  | 21204<br>8315 Loch Raven Blvd., Apt. A  |  |            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |         |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |   |  |  | 16b. SOCIAL SECURITY NO.  |  |            |  |
| Harry F. Steedman  |  |         |                   | Kathryn G. VanOrder  |  |   |  | No  |   |  |  | 214-40-7432   |  |            |  |
|  |  |         |                   | 17. INFORMANT<br>ADDRESS   |  |   |  |   |   |  |  | Mark M. Steedman -606 Cannon St. 21620  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |         |                   |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.   |  |         |                   |  |  |   |  |   |   |  |  |   |  |            |  |
| 19a. DATE OF OPERATION   |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |            |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |  |            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |                   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |                   |  |  |   |  |   |   |  |  |   |  |            |  |
| ACTUAL<br>SIGNATURE  |  |         |                   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE<br>SIGNED 7/14/86  |   |  |  |   |  |            |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |         |                   | ADDRESS  |  |   |  |   |   |  |  |   |  |            |  |
| William M. Zane, M.D.  |  |         |                   | 111 Penn St. Balto.MD.   |  |   |  |   |   |  |  |   |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |         |                   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY        |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |  |            |  |
| Cremation  |  |         |                   | 7-15-86  |  | Westview Crematory                        |  |   |   | Balto. MD.                                 |  |   |  |            |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |         |                   | ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |            |  |
| Ruck Towson Funeral Home, Inc.   |  |         |                   | Towson, Md. 21204  |  |   |  | JUL 17 1986   |   |  |  | Julia Davidson  |  |            |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS PAK 3, REMAINING PAGES 5, FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-1001-00)  
SUBJECT: [Illegible]

|      |             |
|------|-------------|
| DATE | 10/1/68     |
| TIME | 10:00 AM    |
| BY   | [Illegible] |
| FOR  | [Illegible] |

00-13309

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 9 0 5 3

|  |  |  |   |   |  |  |   |   |  |
|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elsa Anna Steiner</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 19, 1986</b>                   |   |  | 2b. HOUR<br><b>645 p.m.</b>  |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 9, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Co. Baltimore, County MD.</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Receptionist.</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B.G.&amp;E.</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balt.</b>   |   | 13c. CITY OR TOWN<br><b>Cockeysville</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roman W. Steiner</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Anstett</b>           |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Rt. 1, Box 123 Ivy Hill Rd. 21030</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-3078</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Stella Maris Hospice, Towson, Md. 21204</b>     |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Atherosclerotic Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b>   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>80</b> , to <b>July</b> , 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>July 18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Carla A. Alexander, MD</b>  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/19/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla A. Alexander, M.D.</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>Stella Maris Hospice, Dulaney Val. Rd. Towson 21204</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7-23-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 24 1986 Julia Davidson-Randall</b>  |   |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain this certificate on your papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Herbert G. STEVENS  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>7 19 86  |  | 2b. HOUR<br>8:00a M  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 23 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |  |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Balto. Highlands  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2819 Michigan Avenue |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Insurance Agent |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Insurance Sales  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Balto. Highlands  |  |   |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 18. STREET ADDRESS / ZIP CODE<br>2819 Michigan Avenue, 21227 |  |  |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John G. Stevens  |  |   |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Jordan  |  |  |  |  |  |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 21b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-12-5485  |  | 22. INFORMANT ADDRESS<br>Herbert L. Stevens, 2821 Pennsylvania Ave.  |  |  |  |  |  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease 5+ years</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |  |  |  |  |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes   |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Cole M.D.   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/19/86                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Jeffrey Cole  |  |   |  |  | 22e. ADDRESS<br>St. Agnes Hospital   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/22/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland             |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.,  |  |   |  |  | ADDRESS<br>4107 Wilkens Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 21 1986                 |  | 25b. REGISTRAR'S SIGNATURE<br>John A. Davidson |  |

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

00-13087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19055  
REG. NO.

|   |  |  |   |   |   |  |   |   |  |
|---|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELIZABETH N. STIRLING</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 20 86</b>                    |   | 2b. HOUR<br><b>10:05 PM</b>   |  |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 15, 1905</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS MONTHS DAYS HOURS MIN.               |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED CLECK</b> |   |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HECHT CO.</b>   |  |  |   |   |   |  |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY G. EBEN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AUGUSTA HITCHCOCK</b> |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>223-18-7668</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>MRS. ELIZABETH JANE CAROTHERS</b>  |  |  |   |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aortic Regurgitation</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7/16 19 86</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7/16 19 86</b>  |   | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7/20 19 86</b>                   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> 19 <b>86</b> , to <b>7/20</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/20</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Arthur A Smith</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><b>7/20/86</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur A Smith</b>  |  |  |   | 22e. ADDRESS<br><b>GBMC 6701 N. CHARLES ST. TOWSON MD</b>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>7/23/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>COCKEYSVILLE BALT MD</b>                |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ELINE FUNERAL HOME REISTERSTOWN</b>  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>JUL 22 1986</b>  |   |  |   |   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Harrison</b>   |   |  |   |   |  |

ELINE FUNERAL HOME HEISTERSTOWN

DOUGLASS VALLEY

DOUGLASS VALLEY BALD MD

ELINE FUNERAL HOME HEISTERSTOWN

DOUGLASS VALLEY

DOUGLASS VALLEY

DOUGLASS VALLEY

HENRY

JOHN

INDUST

HITC COOK

ED.

BALTIMORE CIVILS BUREAU

X

1950, WOODBRIDGE DR.

TOWSON

EDWARD M. CHARLES ST.

RETIRED CHECK BOOK

ED.

USA

X

BALTIMORE COUNTY

FEMALE

WHITE

FEB. 12, 1902

81

ELIZABETH W.

STIRLING

OT 20

10:00 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the Registrar within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 19056

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 7-18-86  |  | 4:20 AM   |  |
| Rudolph   |  | Stoecker   |  |  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male  |  | White  |  | 5 21 01  |  | 85  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland  |  | USA  |  |  |  | Baltimore County' MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore County  |  | 417 Riverside Drive 21221  |  | Ret-Steelworker  |  | Eastern Stain- less   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  | Baltimore  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Albert  |  | Mollie   |  | No   |  | 216-07-0187   |  |
| 17. INFORMANT   |  | ADDRESS  |  | 17a. DATE OF OPERATION   |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| Calvin W. Reese   |  | 227 Division Ave. 21093  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | 20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
|   |  | METASTATIC DISEASE   |  |  |  |   |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
|   |  | COLON CARCINOMA  |  |  |  |   |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
|   |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  | P.M. 19  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. INJURY OCCURRED  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21c. LOCATION  |  | 21d. DATE SIGNED  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  | 7-18-86   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from  |  | 22b. SIGNATURE   |  | 22c. DEGREE  |  | 22d. DATE SIGNED  |  |
| Feb. 18 19 81 to July 16 19 86  |  | Theodore Paglinauan, M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 7-18-86   |  |
| saw the deceased alive on June 14 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22f. ADDRESS   |  | 22g. DATE REC'D. BY REGISTRAR                                       |  |
|   |  | Theodore Paglinauan, M.D. (687-8818)   |  | Golden Ring Med. Ctr. 8552 Phila. Rd. 21237  |  | 7-21-86   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial  |  | 7-21-86  |  | Dulaney Valley M.G.  |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE  |  |
| NAME ADDRESS  |  | 7-21-86  |  | Hassan Funeral Home  |  | BALTO. MD. 21236  |  |

BP

0-6-10323-6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19057

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Vance E. Stoval</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 18 86</b>  |  | 2b. HOUR-<br><b>2:53am</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 17, 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC, 6701 N. Charles St., Towson</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Equip. Operator.</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>11</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Stoval</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Hamm</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-10-3550</b>  |   | 17. INFORMANT<br><b>Betty Stoval</b> ADDRESS <b>same as 13 e</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |   |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>COPD, Progressive Clotting, Post-statis By-Pass</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>7/16/86</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aortic Bifemoral By-pass</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/15</b> , 19 <b>86</b> , to <b>7/18</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Frank A. Faraino</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/18/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Frank Faraino</b>  |   | 22e. ADDRESS<br><b>GBMC, 6701 N. Charles St., Towson, MD 21204</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>7-21-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 21 1986</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |   | ADDRESS<br><b>5305 Harford Rd. 21214</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                                     |  |

BP

100-3-1

Nov. 17, 1913  
U.S.A.  
Baltimore  
210-10-3550  
Betsy Goveal  
same as 13 a

210-10-3550  
Betsy Goveal  
same as 13 a

210-10-3550  
Betsy Goveal  
same as 13 a

00-11974

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8619058  
REG. NO.

|  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Virginia Stump  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 8, 1986  |  | 2b. HOUR<br>4:25 AM                             |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 19 1918                             |   |  |
| 6. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>800 Southerly Road |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                  |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>U.S.A.  |  | 13c. CITY OR TOWN<br>Towson                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert L. Sullivan   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Santmyer  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-10-2943  |  | 17. INFORMANT<br>ADDRESS<br>Elmer Stump 17 Killala Court 21093                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Dissecting Aortic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>History of Aortic Aneurysm of Aorta</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>86</u> , to <u>July</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Benjamin R. Yorkoff</u>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/8/86                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Benjamin R. Yorkoff, M.D.   |  |   | 22e. ADDRESS<br>7600 Osler Drive Towson, Md.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-11-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park                            |   |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Maryland   |  | COUNTY<br>Baltimore   |  | STATE<br>Maryland  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |  |   | 25a. DATE REC'D BY REGISTRAR<br>JUL 10 1986  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 5 9

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| Barbara SUTTON  |  | July 27, 1986  |   | 9:20PM   |                                   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR   |                                   |
| FEMALE  | CAUCASIAN  | 07 28 51   | 35 YRS  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |
| PENNSYLVANIA  | USA  |  | Baltimore County MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| ROSSVILE  | FRANKLIN SQUARE HOSPITAL   |  | HOUSEWIFE   |  | -----                             |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| MARYLAND  |  | BALTIMORE  | BALTIMORE   | 13e. STREET ADDRESS / ZIP CODE   |                                   |
|   |  |  |   | 17 DECATUR RD. 21220   |                                   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| CLYDE WALTERS   |  | BARBARA HOUKENBERRY  |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |
| NO  |  | 216583236  |   | JOHN SUTTON 17 DECATUR RD.   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                                   |
| IMMEDIATE CAUSE (a) Pneumonia   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) Micronodular Cirrhosis   |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from July 22, 1986, to July 27, 1986 that (I) (we) last saw the deceased alive on July 27, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |   |  |                                   |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| Dr. Samman, M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   | 7.21.86  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |                                   |
| Dr. Samman, M.D.  |  | 9000 Franklin Square Drive- 21237  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| BURIAL  |  | 07/30/86   |   | GARDENS OF FAITH   |                                   |
| 23d. LOCATION   |  | 23e. COUNTY  |   | 23f. STATE   |                                   |
| BALTO.  |  | BALTO.   |   | MD.  |                                   |
| 24. FUNERAL DIRECTOR  |  | 24b. ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| J. J. Wood  |  | 1211 Chesapeake Ave.   |   | JUL 29 1986  |                                   |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
|   |  |  |   | Julia Davidson-Rindell   |                                   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and date, and return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                           |  |  |
|--|--|--|--|---|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John R. Sweeney</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>7 10 86</b> |   | 2b. HOUR<br><b>10 A M</b> |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 19 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>  |                           | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. City</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore County</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Towson Convalescent Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>salesman</b>             |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Parisers' Bakery</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto City</b>   |  | 13c. CITY OR TOWN<br><b>Balto City</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 13e. STREET ADDRESS<br><b>602 Cedarcroft Rd., 21212</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raymond J. Sweeney</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Hooper</b>  |  |   |  |   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-4037</b>   |  | 17. INFORMANT ADDRESS<br><b>Maureen T. Turnbaugh, 1637 Walterswood Rd. Balto., MD 21239</b>   |  |   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebrovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>9 yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b> |  |  |  |   |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |                           |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6100 WORT RD BALTIMORE MD 21212</b>   |  |   |                           |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>JUL 1 1986</b> to <b>JUL 10 1986</b> , that (1) (we) last saw the deceased alive on <b>JUL 5 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |                           |  |  |
| 22b. SIGNATURE<br><b>Walter R. Welzant</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |                           | 22c. DATE SIGNED<br><b>JUL 10, 1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER R. WELZANT MD</b>   |  | 22e. ADDRESS<br><b>6100 WORT RD BALTIMORE MD 21212</b>   |  |   |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-14-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Balto., Md</b>                          |                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>John C. Miller, Inc., 6415 Belair Rd. 21206</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 15 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>   |                           |  |  |

BP

*[Faint, illegible handwriting on lined paper]*



0-12015

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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| STATE OF MARYLAND  |  |  |  |  |  |  |  |  |  |
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| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
| 1- STATE REGISTRAR 8-14  |  |  |  |  |  |  |  |  |  |
| REG. NO. 19061   |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN R SWETZ  |  |  |  |  |  |  |  |  |  |
| 2a DATE KNOWN OF DEATH MONTH DAY YEAR July 8 1986  |  |  |  |  |  |  |  |  |  |
| 2b DATE PRONOUNCED DEAD MONTH DAY YEAR July 8 1986   |  |  |  |  |  |  |  |  |  |
| 3 SEX F 4 RACE W 5 DATE OF BIRTH MONTH DAY YEAR 09-24-25 6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH BALTIMORE 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) TOWSON ST JOSEPH HOSPITAL 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b KIND OF BUSINESS OR INDUSTRY HOME   |  |  |  |  |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD BALTIMORE BALTIMORE 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS 8024 DALESFORD RD 21234   |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST FRANK SZCZEPUCHA 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGDELENE YAYECNIK   |  |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 213-20-8663 17 INFORMANT ADDRESS ANTHONY SWETZ, SR. BALTIMORE, MD 21234   |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose Amyl triptyline DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE 8024 Dalesford Rd Baltimore MD   |  |  |  |  |  |  |  |  |  |
| 22a I certify that I took charge of the remains described above, held on death resulted from Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 7/9/86   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) CHARLES F. O'DONNELL, MD. ADDRESS 7501 YORK RD. 21204  |  |  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE JULY 11, '86 23c NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS CEMETERY 23d LOCATION CITY OR TOWN COUNTY STATE GARRISON FOREST, MD  |  |  |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON 25a DATE REC'D. BY REGISTRAR JUL 10 1986 25b REGISTRAR'S SIGNATURE [Signature]   |  |  |  |  |  |  |  |  |  |

15012



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 6 2

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Birdie M. Sydes</b>                                |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>16</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>M</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>10</b> YEAR <b>1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>432 E. Pennsylvania Ave</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>432 E. Pennsylvania Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>Johnson</b> LAST <b>Johnson</b>           |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Susie</b> MIDDLE <b>Johnson</b> LAST <b>Johnson</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>            |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-5938</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rev. Joseph McManus 417 Jefferson St.</b>  |  |   |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio sclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |
|---|--|--|--|

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>June 19 68</b> to <b>NOVEMBER 19 85</b> , that (1) (we) lost<br>saw the deceased <b>November 22 19 85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Samuel R. Owings, Jr., M.D.</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |  |  | 22c. DATE SIGNED<br><b>7-17-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel R. Owings, Jr.</b>   |  |  |  | 22e. ADDRESS<br><b>909 N. CAREY ST. Balto., Md 21217</b>                       |  |   |  |

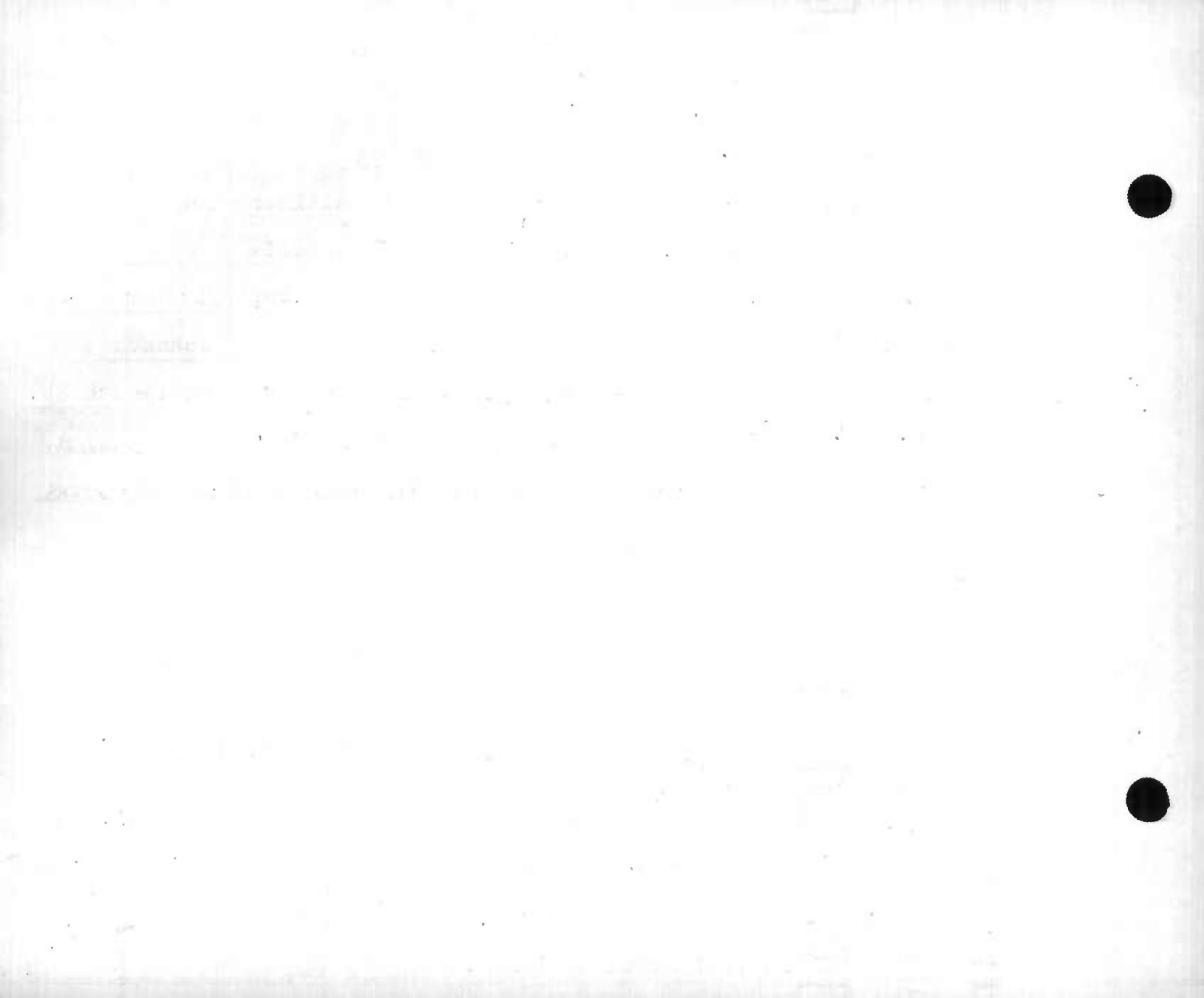
|  |  |                             |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>                          |  | 23b. DATE<br><b>7/23/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Chatman-Harris</b><br>ADDRESS<br><b>FH 1701 McCulloh Street</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                 |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



0-13597

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  | REG. NO. 86 19063   |  |          |  |
|--|--|---|--|--|--|---|--|---|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLOTTE H SZURIEWICZ</b>  |  |   |  |  |  |   |  |   |  | MONTH DAY YEAR <b>7 26 86</b>                                     |  | 8:45 PM  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 30 34</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                                     |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                                |  |   |  |   |  |          |  |
| 11. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |          |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3105 WESTFIELD AVE, 21214</b>  |  |   |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cyril Alcantara</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Sobieski</b>   |  |   |  |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF NOT IN SUCH FACILITY, GIVE WAR OR DATES)<br><b>212-30-5884</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Joann M. Nugent 5424 Harford Rd. 21214</b>  |  |   |  |   |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES, MARKED ARTERIOSCL CARDIOVASC DIS.</b>                         |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |  |          |  |
|  |  |   |  |  |  |   |  |   |  | <b>2 DAYS</b>   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>(RELATED) - CEREBRAL NEURITIS, PULM CONGESTION, ACUTE TUBULAR NECROSIS, ISCH. CORONARTS</b>   |  |   |  |  |  |   |  |   |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> , 19 <b>86</b> , to <b>7/26</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  | 22c. DATE SIGNED<br><b>7/27/86</b>                                |  |          |  |
| 22b. SIGNATURE<br><b>JAMES W. EAGAN, JR., MD</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. EAGAN, JR., MD</b>  |  |   |  | 22e. ADDRESS<br><b>DEPT. OF PATH, ST. JOSEPH HOSP, TOWSON, MD</b>  |  |   |  |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jul 30 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 28 1986</b>                  |  |   |  |   |  |          |  |

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00-1185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

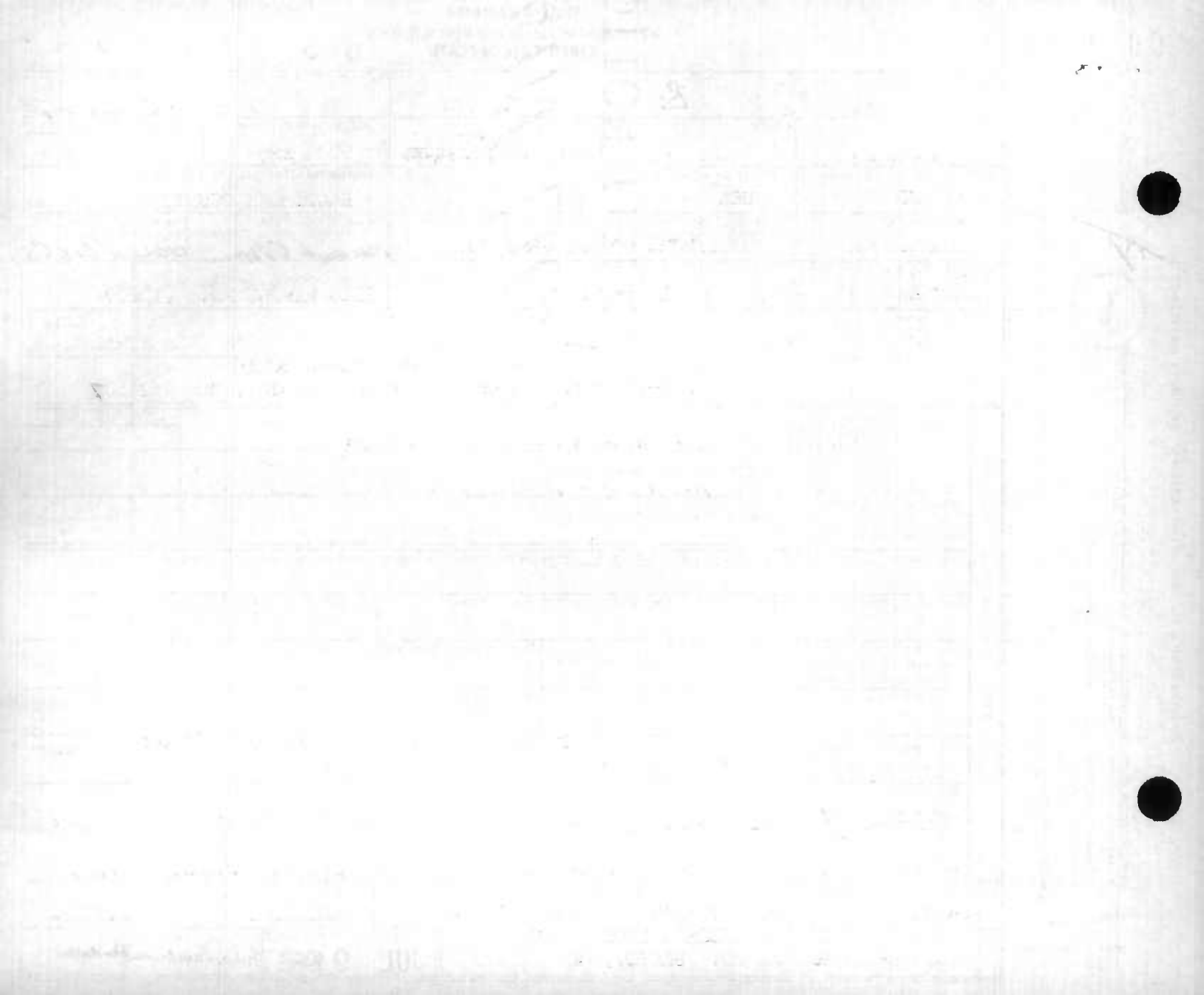
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                                  |  |
|--|--|--|--|--|--|--|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  | REG. NO.                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR                         |  |
| Bessie R. Taylor   |  |  |  | 7-5-86   |  | 11:59 AM   |  |                                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR                  |  |
| Female   |  | White  |  | UNKNOWN<br>MONTH YEAR<br>XXXXXXXXXXXX  |  | 90 3x7 YRS   |  | IF UNDER 24 HRS                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                                  |  |
| MARYLAND   |  | USA  |  |  |  | BALTIMORE COUNTY   |  | MD.                              |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                  |  |
| RANDALLSTOWN   |  | BALTIMORE COUNTY GEN. HOSP.  |  | MACHINE OPER.  |  | GOLDEN BOX CO.   |  |                                  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |                                  |  |
| MARYLAND   |  | BALTO.   |  | BALTIMORE  |  | 3328 RIPPLE RD. #12207   |  |                                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT                    |  |
| SIMON  |  | LOUIS TAYLOR   |  | LENA ROSENTHAL   |  | NO   |  | MRS. SONYA SODIE                 |  |
|  |  |  |  |  |  | 216-10-3980  |  | 3328 RIPPLE RD. BALTO., MD 21207 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |                                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |                                  |  |
| IMMEDIATE CAUSE (a) <u>Cardiac stroke</u>  |  |  |  |  |  |  |  |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                                  |  |
| (b) <u>Acute myocardial infarction</u>   |  |  |  |  |  |  |  |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                                  |  |
| (c) <u></u>  |  |  |  |  |  |  |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |  |  |  |  |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                                  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |                                  |  |
|  |  | P.M. 19  |  |  |  |  |  |                                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY STATE                     |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  |  |  |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-12</u> , 19 <u>86</u> , to <u>7-5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                                  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED   |  |                                  |  |
| <u>Sol Levinson M.D.</u>   |  |  |  |  |  | 7-6-86   |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |                                  |  |
| <u>Sol Levinson</u>  |  | <u>Baltimore County General Hosp</u>   |  |  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | CITY OR TOWN COUNTY STATE        |  |
| BURIAL   |  | JULY 7, 1986   |  | BNAI ISRAEL  |  | BALTIMORE  |  | BALTIMORE MARYLAND               |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                  |  |
| SOL LEVINSON & BROS., INC.   |  | JUL 9 1986   |  | <u>Sol Levinson</u>  |  |  |  |                                  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  |  |  |                                  |  |



00-12112

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

19065

REG. NO.

|   |  |  |                   |  |  |   |  |
|---|--|--|-------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |                   | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| James Lee THOMPSON  |  |  |                   | July 8, 1986   |  | 1:08a M   |  |
| 3 SEX   | 4 RACE   | 5. DATE OF BIRTH MONTH DAY YEAR  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.  |  |
| Male  | White  | Feb. 12 1934   |                   | 56 YRS   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| W.VA.   | USA  |  |                   | Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Rossville   | Franklin Square HOSPITAL   |  |                   | Fork Lift Operator   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE  |  |
| Md.   |  | Balto.   | Essex             |  |  | 8 National Drive 21221  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                   |  |  |   |  |
| Joseph M. Thompson  |  | Florice Bonnell  |                   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT ADDRESS  |  |   |  |
| no  |  | 235-50-8804  |                   | Ora Jackson Thompson 8 National Dr.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |                   |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                   |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |  |  |                   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                   |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |                   |  |  |   |  |
| (b) <u>Poorly Differentiated Large Cell Carcinoma of Lung</u>   |  |  |                   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                   |  |  |   |  |
| (c)   |  |  |                   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |                   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
|   |  | P.M. 19  |                   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |  |                   |  |  |   |  |
| 22a. I certify that X (this hospital) attended the deceased from July 7, 19 86, to July 8, 19 86, that X (we) lost saw the deceased alive on above, X (we) did not view the body after death. |  |  |                   |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| <i>Ken Curry</i>  |  |  |                   |  |  | 7-8-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |                   |  |  |   |  |
| Ken Curry, M.D.   |  | 9000 Franklin Square Dr., 21237  |                   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Cremation   |  | 7/11/86  |                   | Security Process   |  | Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |                   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| ConnellyFuneralHome 300MaceAve. 21221   |  |  |                   | JUL 11 1986  |  | <i>[Signature]</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical death certificate must be notified at once.

BP

THE UNITED STATES OF AMERICA

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE GENERAL LAND OFFICE

TO THE SENATE

IN RESPONSE TO A RESOLUTION PASSED MAY 1, 1899

AND TO A RESOLUTION PASSED MAY 1, 1900

OF THE SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (legibly) filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|  |   |   |   |
|--|---|---|---|
| Item # 15, Film G 621, 11.5.85 ra  |   | STATE OF MARYLAND   |   |
| 1- FOR STATE REGISTRAR   |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |
| 00-13031   |   | CERTIFICATE OF DEATH  |   |
| 1 DECEASED NAME (TYPE OR PRINT) <b>JEANETTE F. THOMPSON</b>  |   | 2a DATE OF DEATH MONTH DAY YEAR <b>JUL 19 1986</b> 2b. HOUR <b>9 PM</b>   |   |
| 3 SEX <b>FEMALE</b>  | 4 RACE <b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1914</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>   |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesperson</b>  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 13a. STATE <b>Maryland</b>   | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Carney</b>   | 13e. STREET ADDRESS / ZIP CODE <b>4 Revere Court 21234</b>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Carter</b>  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jeanette Laurie Not Known</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  | 16b. SOCIAL SECURITY NO. <b>212-07-9511</b>   | 17. INFORMANT ADDRESS <b>Elaine F. Thompson 4 Revere Ct. 21234</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatous</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>do. / 85</b>  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1972</b> , 19____, to <b>Pres</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE <b>Robert J. Mahon MD</b>   | DEGREE <b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              | 22c. DATE SIGNED <b>7/20/86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. MAHON MD</b>  |   | 22e. ADDRESS <b>St Joseph Hosp. Towson MD 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  | 23b. DATE <b>Jul 23 1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1986</b> 25b. REGISTRAR'S SIGNATURE   |   |

BP

|          |                  |                     |           |
|----------|------------------|---------------------|-----------|
| 75       | 1914             | White               | U.S.A.    |
| 112-0-11 | Alma K. Thompson | Revere Co. 112-0-11 | NOT KNOWN |
| 112-0-11 | Alma K. Thompson | Revere Co. 112-0-11 | NOT KNOWN |

112-0-11  
 Alma K. Thompson  
 Revere Co. 112-0-11  
 NOT KNOWN

112-0-11  
 Alma K. Thompson  
 Revere Co. 112-0-11  
 NOT KNOWN

112-0-11  
 Alma K. Thompson  
 Revere Co. 112-0-11  
 NOT KNOWN

00-11980

FOR  
1- STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19067

|   |         |                  |  |                   |                      |   |  |  |   |  |  |
|---|---------|------------------|--|-------------------|----------------------|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | 2. DATE KNOWN OF DEATH   |                   |                      | 3. DATE OF DEATH  |  |  | 4. HOUR   |  |  |
| Karl-Eric R. Thorssell  |         |                  | June 30 1986   |                   |                      | July 2 1986   |  |  | 9 P.M.  |  |  |
| 5. SEX  | 6. RACE | 7. DATE OF BIRTH | 8. AGE (YEARS)   | 9. IF UNDER 1 YR. | 10. IF UNDER 24 HRS. | 11. DATE PRONOUNCED DEAD  |  |  | 12. HOUR  |  |  |
| Male  | White   | 12 20 1920       | 65 YRS.  |                   |                      | July 2 1986   |  |  | 2 P.M.  |  |  |
| 13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 14. CITIZEN OF WHAT COUNTRY?   |                   |                      | 15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 16. BALTIMORE CITY OR COUNTY OF DEATH                               |  |  |
| Sweden  |         |                  | U.S.A.   |                   |                      |   |  |  | Baltimore County MD   |  |  |
| 17. CITY OR TOWN OF DEATH   |         |                  | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                   |                      | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 20. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Lutherville   |         |                  | 801 Morris Ave. 21093  |                   |                      | Limo-Type Operator  |  |  | A.S. Able Co.   |  |  |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |                  | 22. STATE  |                   |                      | 23. CITY OR TOWN  |  |  | 24. INSIDE CITY LIMITS?   |  |  |
| Maryland  |         |                  | Balto.   |                   |                      | Lutherville   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 25. STREET ADDRESS  |         |                  | 26. CITY OR TOWN   |                   |                      | 27. INSIDE CITY LIMITS?   |  |  | 28. STREET ADDRESS  |  |  |
| 801 Morris Ave. 21093   |         |                  | Lutherville  |                   |                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 801 Morris Ave. 21093   |  |  |
| 29. FATHER'S NAME   |         |                  | 30. MOTHER'S MAIDEN NAME   |                   |                      | 31. INFORMANT   |  |  | 32. ADDRESS   |  |  |
| Ragner J. Thorssell   |         |                  | Maria C. Nilsson   |                   |                      | Mrs. Dorothy Thorssell  |  |  | Same as 13e   |  |  |
| 33. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |                  | 34. SOCIAL SECURITY NO.  |                   |                      | 35. INFORMANT   |  |  | 36. ADDRESS   |  |  |
| Yes   |         |                  | W.W.LL   |                   |                      | 216-10-7341   |  |  | Mrs. Dorothy Thorssell  |  |  |
| 37. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  | 38. IMMEDIATE CAUSE (a)  |                   |                      | 39. DUE TO, OR AS A CONSEQUENCE OF  |  |  | 40. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |  |
| PART 1 DEATH WAS CAUSED BY:   |         |                  | Cardiac Arrest   |                   |                      | Sudden  |  |  | 5 yrs   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last  |         |                  | (b) #3 CVD   |                   |                      | DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                     |         |                  |  |                   |                      |   |  |  |   |  |  |
| 41. DATE OF OPERATION   |         |                  | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |                      | 43. AUTOPSY?  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 44. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         |                  | 45. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                   |                      | 46. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |
| 47. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         |                  | 48. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   |                      | 49. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 50. I certify that I took charge of the remains described above, held on death resulted from:   |         |                  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                   |                      | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                        |  |  |   |  |  |
| 51. ACTUAL SIGNATURE  |         |                  | 52. TITLE SPECIFY  |                   |                      | 53. MEDICAL EXAMINER  |  |  | 54. DATE SIGNED   |  |  |
| Charles O' Donnell M.D.   |         |                  | 7501 York Rd.  |                   |                      |   |  |  | 7/2/86  |  |  |
| 55. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 56. DATE   |                   |                      | 57. NAME OF CEMETERY OR CREMATORY   |  |  | 58. LOCATION CITY OR TOWN COUNTY STATE                              |  |  |
| Burial  |         |                  | 7/7/86   |                   |                      | Moreland Memorial Pk.   |  |  | Balto. Balto. Md.   |  |  |
| 59. FUNERAL DIRECTOR NAME   |         |                  | 60. ADDRESS  |                   |                      | 61. DATE REC'D. BY REGISTRAR  |  |  | 62. REGISTRAR'S SIGNATURE   |  |  |
| Ruck Towson Funeral Home, Inc.  |         |                  | 1050 York Rd.  |                   |                      | JUL 10 1986   |  |  |   |  |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 72 HOURS. PAGES 2, 3, AND 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS CERTIFICATE. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Info. per F.H. 7/1/86 kam  |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
|--|--|---------|---|-----------------------------|------------------------------------|---|--|--|--|---|-----------------------------------|--------------------------------|--|
| STATE OF MARYLAND  |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| CERTIFICATE OF DEATH   |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| REG. NO. 86 19068  |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST   |                             |                                    | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR   |   |                                   |                                |  |
| Stuart Price   |  |         | Threlkeld   |                             |                                    | 6 / 28 / 1986   |  |  | 1:00 P   |   |                                   |                                |  |
| 3 SEX  |  | 4. RACE |   | 5. DATE OF BIRTH            |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                            |  | IF UNDER 24 HRS.  |                                   |                                |  |
| Male   |  | White   |   | MONTH DAY YEAR<br>6 21 1912 |                                    | 74 YRS.   |  | MONTHS DAYS                                |  | HOURS MIN.  |                                   |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                             |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |                                |  |
| Kentucky   |  |         | U.S.A.  |                             |                                    |   |  |  | Baltimore County, MD.  |   |                                   |                                |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                             |                                    |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                |  |
| Dundalk  |  |         | 1755 Drexel Road 21222  |                             |                                    |   |  |  | Meat Packer  |   | Wholesale food                    |                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         |   |                             |                                    |   |  |  |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS / ZIP CODE |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |         |   |                             |                                    |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 1755 Drexel Road 21222         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |         |   |                             |                                    |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                            |                                   |                                |  |
| Oren Gladden Threlkeld   |  |         |   |                             |                                    |   |  |  |  | Nora Price  |                                   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |         | 16b. SOCIAL SECURITY NO.  |                             |                                    | 17. INFORMANT   |  |  | ADDRESS  |   |                                   |                                |  |
| No   |  |         | 403.05.3930A  |                             |                                    | Virginia L Threlkeld  |  |  | (same as 13e)  |   |                                   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>   |  |         |   |                             |                                    |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |                                   | 1 hour                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |         |   |                             |                                    |   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of lung &amp; metabolism</u> |                                   | 6 mo.                          |  |
|  |  |         |   |                             |                                    |   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Smoking, Emphysema</u>          |                                   | 50 yrs.                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>   |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             |                                    |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |   |                                   |                                |  |
|  |  |         |   |                             |                                    |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |                                   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                             |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |                                   |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                             |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                                   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-21</u> , 19 <u>76</u> , to <u>6/30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |   |                             |                                    |   |  |  |  |   |                                   |                                |  |
| 22b. SIGNATURE<br><u>Hector L Feliciano, MD.</u>   |  |         |   |                             |                                    | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  | 22c. DATE SIGNED   |   |                                   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |         |   |                             |                                    | 22e. ADDRESS  |  |  |  |   |                                   |                                |  |
| Hector L Feliciano, MD.  |  |         |   |                             |                                    | 7200 North Point Road   |  |  |  |   |                                   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         | 23b. DATE   |                             | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |                                   |                                |  |
| Burial   |  |         | 7/1/1986  |                             | Oak Lawn Cemetery                  |   |  | Baltimore MD                               |  |   |                                   |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |         |   |                             |                                    | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |                                   |                                |  |
| Walter Brooks Bradley, Inc. Balto., MD 21222   |  |         |   |                             |                                    | JUN 30 1986 <u>[Signature]</u>  |  |  |  |   |                                   |                                |  |



00-13384

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

19069

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret S. TRAEG  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>7 23 86                                 |   | 2b HOUR<br>11:45A.M.   |
| 3 SEX<br>Female  | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 27 1900   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Ruxton   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br>Manor Care Ruxton |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Drug Clerk | 12b KIND OF BUSINESS OR INDUSTRY<br>Pharmacy  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin F. Snavelly  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Butschky   |   | 13e STREET ADDRESS / ZIP CODE<br>1312 Sherwood Ave. 21239                                       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b SOCIAL SECURITY NO.<br>219-10-0567   |   | 17 INFORMANT ADDRESS<br>Marilyn T. VanCutsem Same   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4-5 min.<br>4-5 min.<br>10-20 yrs. |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Sepsis due to catheter/dressings</u>   |   |  |   |   |  |
| 19a DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |
| 21d INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6/14</u> 19 <u>86</u> , to <u>7</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.               |   |  |   |   |  |
| 22b SIGNATURE<br>Dan McDougal  |   | DEGREE<br>MD   |   | 22c DATE SIGNED<br>7/23/86  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MCDUGAL  |   | 22e ADDRESS<br>GOOD SAM #306   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b DATE<br>7-25-86  |   | 23c NAME OF CEMETERY OR CREMATORY<br>Druid Ridge  |  |
| 23d LOCATION<br>Pikesville   |   | COUNTY<br>Balto.   |   | STATE<br>Md.  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.  |   | ADDRESS<br>4905 York Rd.   |   | 25a DATE REC'D. BY REGISTRAR<br>JUL 24 1986   |  |
|  |   |  |   | 25b REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be conducted.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-12107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO STATE DEPT. OF HEALTH AND MENTAL HYGIENE: Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|   |  |   |   |   |   |  |  |  |   |  |  |
|---|--|---|---|---|---|--|--|--|---|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |  |   | 8619070                                      |  |
| FOR STATE REGISTRAR   |  |   |   |   |   |  |  |  |   | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARGARET MIDDLE DITZEL LAST TRAPP<br><i>Margaret D. Trapp</i>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>7 8 86                            |  | 2b. HOUR<br>10:40 AM   |  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 12, 1903  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                                 |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                               |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland  |  | 13b. CITY OR TOWN Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br>425 Rodgers Ct. 21212  |  |  |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Conrad Ditzel  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Julia Carr GILL Russell |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-03-6855   |   | 17. INFORMANT ADDRESS<br>L.J. Smith 1816 Abelia Rd. 21047   |   |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE ACUTE PULMONARY THROMBOEMBOLISM<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| MEDICAL CERTIFICATION   |  |   |   |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>R. J. Smith</i>  |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>7-8-86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REYNALDO ORJUELA-GOMEZ MD  |  |   |   |   |   | 22e. ADDRESS<br>St. Joseph Hospital  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>7-11-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John Lutheran               |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Blenheim Baltimore Maryland |   |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Road 21212   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 10 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>             |   |  |  |

2025 COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

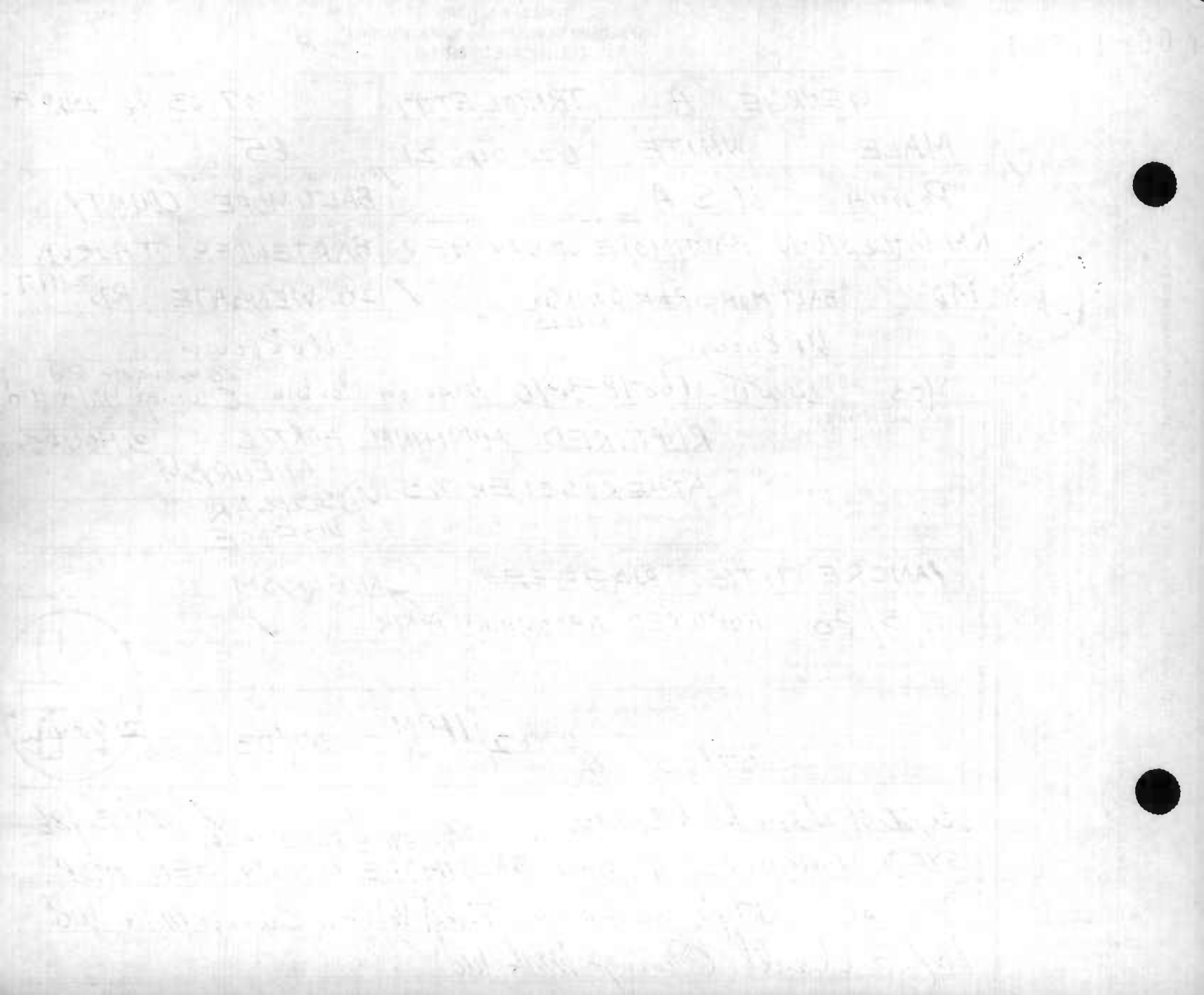
00-11341

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |  |   |
|--|--|---|---|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE A. TRIBOLETTI.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>07</b> DAY <b>03</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>2:48</b> <sup>A</sup> <sub>M</sub>   |  |  |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>04</b> YEAR <b>21</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BARTENDER.</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tavern</b>   |   |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>OWINGS</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>20 WENGATE RD.</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>MILLS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |   |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>166-18-3810</b>   |  | 17. INFORMANT<br>ADDRESS <b>20 Wengate Rd. Owings Mills. Md.</b>  |   |   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC VASCULAR DISEASE.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 HOURS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>PANCREATITIS, DIABETES, ANEURYSM</b>  |  |   |   |   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>07/3/86.</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RUPTURED ABDOMINAL AORTIC</b>  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET <b>07/02/1986</b> CITY OR TOWN <b>OWINGS</b> COUNTY <b>MD.</b> STATE <b>MD.</b>   |  | 22. DATE SIGNED<br><b>07/03/86</b>  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>07/02/1986</b> to <b>07/03/1986</b> , that (I) (we) last saw the deceased alive on <b>07/03/1986</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Syed. Mohsin Ali Hassan</b>   |  |   |   | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>07/03/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SYED. MOHSIN ALI HASSAN.</b>   |  |   |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSP.</b>  |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>July 7, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills</b> COUNTY <b>MD.</b> STATE <b>MD.</b>            |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>A. J. Schhardt</b> ADDRESS <b>Owings Mills Md.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 - 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |

BP



00-12553

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8649072

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |  |   |  |  |
|---|--|---|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Foster Dewitt Trout  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 10 1986                    |   |  | 2b. HOUR<br>10:15 P.M.   |  |  |   |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/6/1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1509 Lanflair Road |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Long Shoreman  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Gemmill Trout  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Orilla V. Smith Trout |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-14-5625  |  | 17. INFORMANT ADDRESS<br>Lena D. Trout, Baltimore, Md. 21221  |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Smoking</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>  |  |   |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7. 11. 86  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. FROZVI   |  |   |  |   |  | 22e. ADDRESS   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>7/14/1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Meth. Cemetery              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Stewartstown, York, Penna. |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ConnellyFuneralHome   |  |   |  |   |  | 24b. ADDRESS<br>300 Mace Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 17 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



00-13501

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19073

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dorothy D. Truitt   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 22, 1986   |  | 2b. HOUR<br>6:00A. M   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 10 1915  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.               |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Dundalk  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>48 Kinship Road |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager - 1st National Bank |  | 15. KIND OF BUSINESS OR INDUSTRY   |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk  |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Spencer Grim  |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Etta Warner                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>220-14-9100  | 17. INFORMANT ADDRESS<br>722 Falconer Road<br>Joppa, Maryland 21085                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) PAD, Mitral Valve Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) S/P Mitral valve Replacement 4/86<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>IN <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 7-16-86 to 7-16-86, that (I) (we) saw the deceased alive on 7-16-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br>VENIEN ALLOID MD  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br>7566 NORTHPOINT RD Belts   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>7/24/1986   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                               | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1986                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.   |  | ADDRESS<br>7922 Wise Avenue Dundalk, Maryland 21222  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, the medical examiner must be notified.



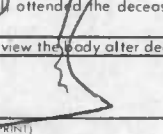
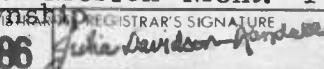
0-11576

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 or 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Cora</b><br><b>CORA</b>  |  |  | MIDDLE<br><b>C.</b>  |  |   | LAST<br><b>TRUXEL</b>  |  |  | REG. NO.   |
| 3 SEX<br><b>Female</b>   |  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>05</b> YEAR <b>08</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS                                |  | 7b HOUR<br><b>435</b> M  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County, MD.</b> |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Stella Maris Hospice</b>         |  |   |  |  |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a STATE <b>Penna.</b> 12b COUNTY <b>Delaware</b> 12c CITY OR TOWN <b>Wallingford</b>   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   | 13e STREET ADDRESS / ZIP CODE<br><b>203 Woodcrest Rd. 19086</b>  |  |  |  |
| 14 FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>L.</b> LAST <b>Newsham</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Edith</b> MIDDLE <b>-</b> LAST <b>Haidee</b>                                   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)<br><b>No</b>   |  |  | 16b SOCIAL SECURITY NO.<br><b>207-26-3722</b>  |  | 17 INFORMANT ADDRESS<br><b>Mrs. Joyce Truxel 406 Wake Robin Dr. Cockeysville, Maryland 21030</b>                    |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>METASTATIC CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF THE BREAST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                      |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/4</b> 19 <b>86</b> to <b>7/3</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>above</b> , (I) (we) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>  |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>7/3/86.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie Nakhuda, M.D.</b>  |  |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>2300 Dulaney Valley Rd. - Towson, MD 21204</b>     |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>7-7-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valley Forge Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upper Merion Mont. Penna.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Monter Delaam</b> ADDRESS <b>10 W. Padonia Rd.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 7 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 7 5

FOR 7/23/86 rja  
STATE REGISTRAR

REG. NO.

00-12185

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AZALIA T. TUCKER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 02 '86                                |  | 2b. HOUR<br>7:25P<br>M   |
| 3. SEX<br>FEMALE  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>December 13, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY<br>MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>GPMC-6701 N. CHARLES ST. |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Sales person | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore   | 13d. STREET ADDRESS / ZIP CODE<br>2904 Glenmore Ave., 21214  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emmett Dickinson  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Stoup                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 14 7703  |  | 17. INFORMANT ADDRESS<br>Ellicott City<br>Mrs Joyce Ortel 4646 Live Oak Ct. 21043        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Breast Cancer<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/02 86 to 7/02 86, that (I) (we) last saw the deceased alive on 7/02 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |  |  |
| 22b. SIGNATURE<br>Charles C. Padgett MD   |  |   |  | 22c. DATE SIGNED<br>7/02/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles Padgett MD   |  |   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd, Baltimore, MD                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>July 5, 1986   | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd Cem.                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City Howard Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry H Witzke & Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1986                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO

FROM

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                     |  |  |   |  |  |  |  |  |   |  |   |  |
|---|--|---|---------------------|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. STATE REGISTRAR  |  |   |                     |  | REG. NO.   |   |  |  |  |  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Sarah <del>Sally</del> L. Vaeth   |  |   |                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 04 86<br>2b. HOUR<br>9:30 P.M. |   |  |  |  |  |  |   |  |   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9/26/28  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |  |  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MAINE  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                     | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |  |  |  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |                     |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |   |  |
| 13a. STATE<br>Md.   |  |   |                     |  | 13b. COUNTY<br>BALTO.  |   | 13c. CITY OR TOWN<br>PIKESVILLE                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEON C. Irish  |  |   |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RUBY CUMMINS            |   |  |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |                     |  | 16b. SOCIAL SECURITY NO.<br>005-24-3672                                  |   | 17. INFORMANT<br>ADDRESS<br>MR. LOUIS W. VAETH PIKESVILLE, Md. |  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Lung Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |                     |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 year  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |                     |  |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 5, 1986, to July 4, 1986, that (I) (we) last saw the deceased alive on July 4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                     |  |  |   |  |  |  | 22b. SIGNATURE<br>D. Wert M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>7/4/86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. Wert  |  |   |                     |  | 22e. ADDRESS<br>GMC--6701 N. Charles Street                              |   |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>7/8/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE CEM.                   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PIKESVILLE, Md.                  |  |  |  |   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>ELINE FUNERAL HOME REISTERSTOWN, Md.   |  |   |                     |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 7 1986                              |   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |

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**THE UNIVERSITY OF CHICAGO**

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 9 0 7 7  
REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lonnie Ray VanGilder</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>July 29, 1986</b>  |  | 2b. HOUR<br><b>6:15 AM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08/17/37</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13211 Maple Grove Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD Baltimore Reisterstown</b>  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>13e. STREET ADDRESS / ZIP CODE<br><b>13211 Maple Grove Ave. 21136</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H. VanGilder</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel V. Smith</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>228-48-5822</b>  | 17. INFORMANT ADDRESS<br><b>E. Dolores VanGilder 13211 Maple Grove Ave. 21136</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Colon with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> , 19 <b>85</b> , to <b>7-29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7-28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Clarence E. McWilliams</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7-30-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLARENCE E. McWilliams</b>   |  | 22e. ADDRESS<br><b>11904 Reisterstown Rd. Reisterstown Md. 21136</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>08/01/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Deer Park Methodist</b>  |   | 23d. LOCATION<br><b>Reisterstown Baltimore, Md.</b>                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>R. Gary Byrd</b> ADDRESS<br><b>ECKHARDT FUNERAL CHAPEL, OWINGS MILLS, MD 21117</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 31 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                    |  |

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NO. 100-100000  
FBI  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

00-13723

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

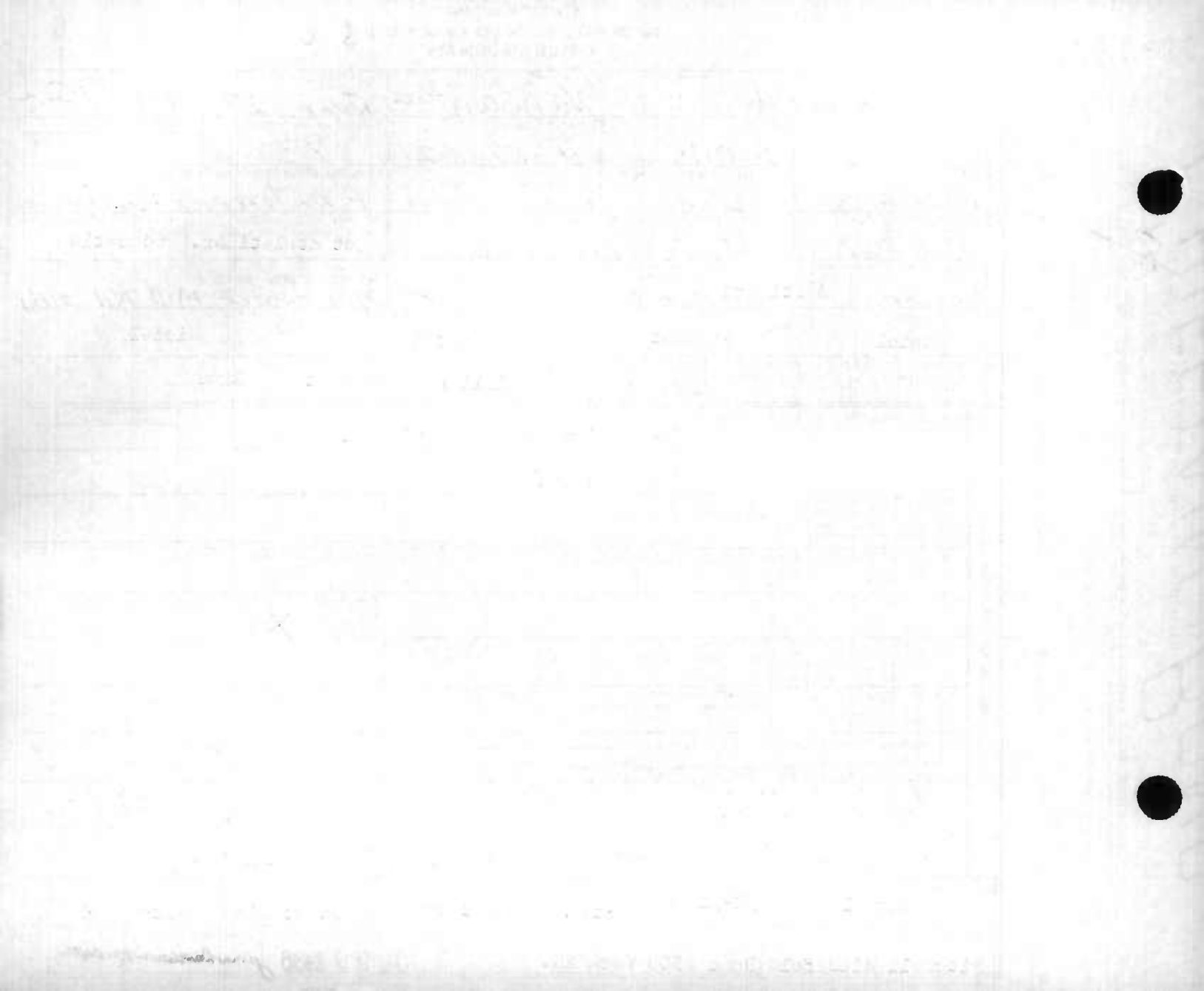
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |   |  |   |  |  |
|--|--|---|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>W. <u>Kenneth</u> <u>Vansant</u> Sr.  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>July</u> <u>27</u> , <u>1986</u> |  |  | 2b. HOUR<br><u>1:15</u> <u>A</u> M  |  |   |  |  |
| 3 SEX<br><u>Male</u>   |  | 4 RACE<br><u>White</u>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10-09-02</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>83</u> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.         |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE</u> <u>County</u> MD.                   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>St. Joseph Hospital</u> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Ret Athletic Dr.</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Education</u>                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MARYLAND</u>  |  |   |   |  | 13b. COUNTY<br><u>Baltimore</u>  |   | 13c. CITY OR TOWN<br><u>White Hall</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Daniel</u> <u>Vansant</u>   |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Sarah</u> <u>Diefel</u>    |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><u>no</u>  |  |   | 16b. SOCIAL SECURITY NO.<br><u>220-22-5437</u>                          |  | 17. INFORMANT ADDRESS<br><u>Lillian H. Vansant</u> <u>Same</u>                 |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>   |  |   |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Robert B. Geller</u>  |  |   |   |  | DEGREE<br><u>MD</u>  |   |  | 22c. DATE SIGNED<br><u>7/27/86</u>                                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ROBERT B. GELLER</u>   |  |   |   |  | 22e. ADDRESS<br><u>ST. JOSEPH'S HOSPITAL</u>                                   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  |   | 23b. DATE<br><u>7/29/1986</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Johns Lutheran</u>                |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Sweet Air Balto Md</u> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Mitchell-Wiedefeld Home 6500 York Rd.</u>   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUL 29 1986</u>                            |   | 25b. REGISTRAR'S SIGNATURE<br><u>Jane Davidson-Gordon</u>                            |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-11340

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 7 9

REG. NO.

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DOROTHY K. VILLA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 2, 1986</b>              |   | 2b. HOUR<br>M<br><b>M</b>   |  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 22, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>69</b>  |   |  |  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNION REPRESENTATIVE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CANNING</b>                       |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>21206</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13d. STREET ADDRESS / ZIP CODE<br><b>4713 DUNCREST RD. 21206</b>   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS WILLIS</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOROTHY GRUBERT</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-12-7239</b>   |   | 17. INFORMANT ADDRESS<br><b>THOMAS P. McCURDY 1720 RED OAK RD. 21234</b>  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MAEDATE</b>          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> , 19 <b>85</b> , to <b>6</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>6/27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Debra H. Carlton MD</b>  |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7/3/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DEBRA CARLTON, M.D.</b>   |  |   |   |   | 22e. ADDRESS<br><b>3411 BANK STREET 552-9520</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>JULY 5, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEM. PARK</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MD</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>   |  |   |   |   | ADDRESS<br><b>8521 LOCH AVEN BLVD.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 - 1986</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b> |  |

BP

3-10-68

2-1-68

000-13386

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 9 0 8 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANITA V. VITALE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 22, 1986</b> |  |  | 2b. HOUR<br>M  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>20 Daria Ct.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Timonium</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Camillo Vanni</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Di Giovanni</b>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>20 Daria Ct. 21093</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-22-1833</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>James W. Vitale -9 Hogarth Cir. Apt. I, 21030</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>86</b> , to <b>July 22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>July 18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Charles A. Padgett</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>7-23-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles A. Padgett, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>Good Samaritan Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-25-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1986</b>  |  |  |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>June Davis</b>  |  |  |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical death certificate must be completed at once.

THE  
LIBRARY  
OF THE  
BOWEN



THE LIBRARY OF THE BOWEN

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

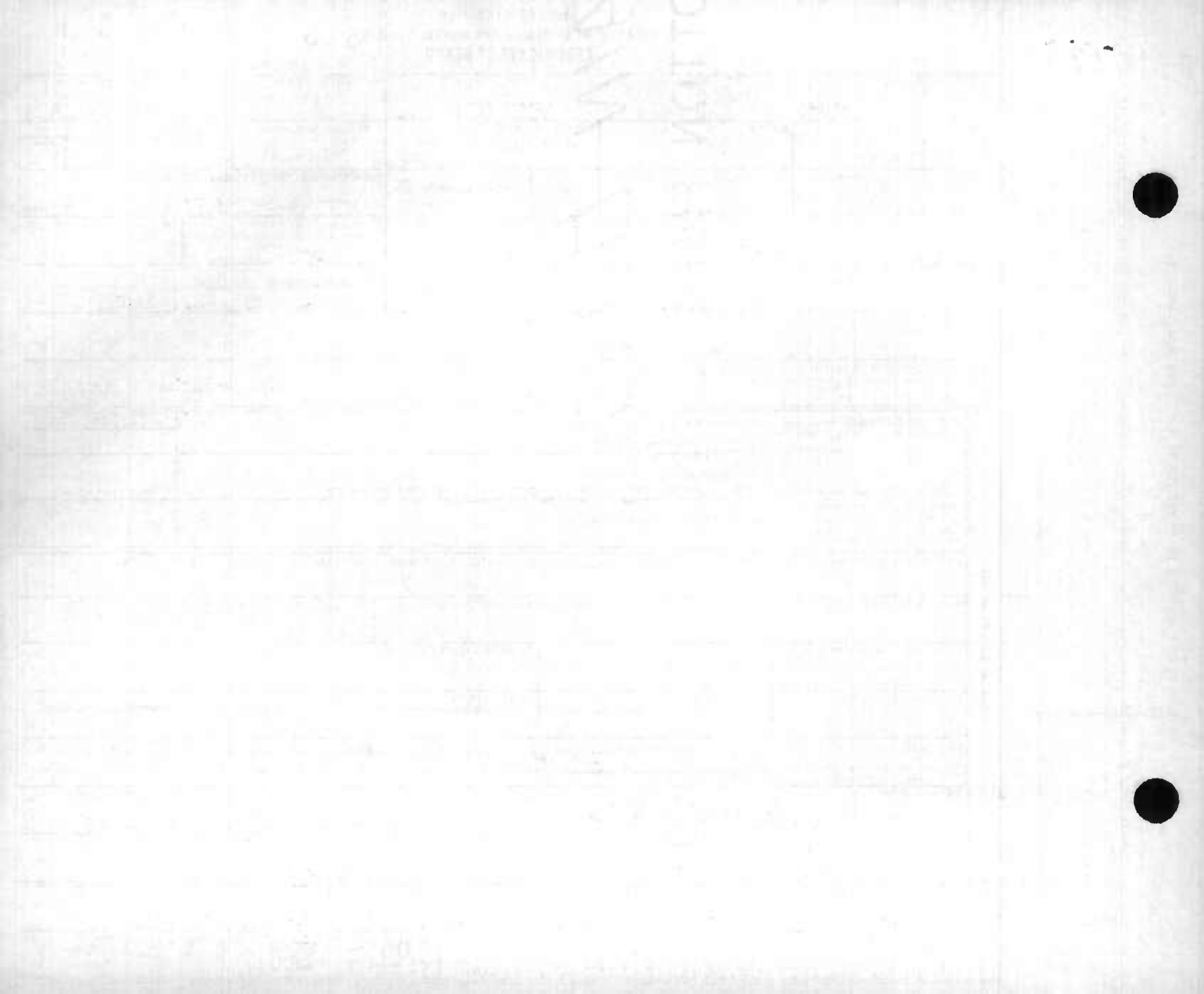
|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARK E VOCKROTH Jr.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 4 86   |  | 2b. HOUR<br>7:15A M                               |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-19-86   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>16                                       |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES STREET |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NA                          | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>Harford   | 13c. CITY OR TOWN<br>Joppa  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mark E. Vockroth Sr.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathleen Fischer   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>-   |   | 17. INFORMANT<br>Mark E. Vockroth Sr.  |   |
|  |  |   |   | ADDRESS<br>408 Berkshire Court<br>Joppa, MD. 21085                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HYPO PLASTIC LEFT HEART SYNDROME</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 DAYS |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-19-86, to 7-4-86, that (I) (we) lost saw the deceased alive on 7-4-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br>G. Karłowicz   |  | DEGREE  |   | 22c. DATE SIGNED<br>7-4-86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY KARLOWICZ, M.D.  |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>7-5-86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. 21215                       |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller Inc.-6415 Belair Rd.-21206  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 8 1986   |   |  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



0-13343

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19082  
REG. NO.

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CARL INGMAN</b>   |  | FIRST<br><b>VOGE</b>   |  | LAST<br><b>VOGE</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 20 1986</b>   |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR 2 1999</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WISCONSIN</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE Co.</b>   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MULTI MEDICAL CENTER</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE</b>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1503 Roundhill Road 21218</b>   |  |  |  |
| 4. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KNUD VOG</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Karn Knudson</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>WWI</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>137093597</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>1107 VAN BUREN ANNAPOLIS MD 21403</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>recurrent + LLL pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3-4 wks</b> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Transitional ca of bladder metastasis</b>   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7/20/86</b>  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/18</b> 19 <b>86</b> to <b>7/20/86</b> 19 <b></b> , that (I) (we) lost saw the deceased alive on <b>7/18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Hans J. Koetter</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>7/21/86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HANS J. KOETTER, M.D.</b>   |  | 22e. ADDRESS<br><b>7600 OSLER DR. BALTO 21204</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/23/1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS AA MD.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>TAYLOR FUN. HOME</b>   |  | ADDRESS<br><b>147 Gloucester St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 23 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 (b) or (c) any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. 1991-1992

0-11349

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 19083

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |  |   |  |
|---|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN A. WAGNER</b>    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-1-86</b> |   | 2b. HOUR<br><b>6</b> <sup>30</sup> <sub>PM</sub>                    |   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept, 22, 1894</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Luke's Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |   |   |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3811 Canterbury Rd., 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Conrad Ernst</b>                           |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Kuhn</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | 16b. SOCIAL SECURITY NO.<br><b>212 40 5511</b>  |  | 17. INFORMANT ADDRESS<br><b>Raughley L. Porter, Balto., MD</b>  |   |   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.10

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>May 7, 1981</b> to <b>July 1, 1986</b> that (b) (we) last saw the deceased alive on <b>August 19, 86</b> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (If (we) did not view the body after death, so state). |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Moges Gebremariam MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-2-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Moges Gebremariam MD</b>   |  |  |  | 22e. ADDRESS<br><b>Wilkins &amp; Beech Aves., Balto., MD</b>   |  |  |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>7/3/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., MD 21212</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1986</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. A. Gordon</i>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Harry W. Jenkins & Sons, Inc.  
100 York Road, Baltimore, MD 21212

Division of Labor Relations

Baltimore, MD

William S. Smith Ave., Baltimore, MD

Contract

Employment

in effect

Site at 8011 Pennsylvania Ave., Baltimore, MD

MD

Baltimore

8011 Contractors Bldg., 21212

St. Luke's Nursing Home

Honorable

Own Home

Baltimore Court

USA

x

1951

1951

19083

10-11948

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

19084

REG. NO.

|  |  |   |   |   |  |  |   |  |  |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Katie K Walker</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>07 09 86</i>                      |   |  | 2b. HOUR<br><i>2:45 AM</i>   |   |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 03 01</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>84</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>County</i> <b>BALTIMORE</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>TOWSON</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Joseph HOSPITAL</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>INSPECTOR</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>BENDIX</i>                        |  |  |
| 13a. STATE<br><i>MARYLAND</i>  |  | 13b. COUNTY<br><i>BALTIMORE</i>   |   | 13c. CITY OR TOWN<br><i>21234</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><i>8216 OAKLEIGH RD. 21234</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>JAMES ROBERT KEMP</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARY CATHERINE HALL</i> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>216-20-1645</i>   |  |   | 17. INFORMANT<br>ADDRESS<br><i>MARY A. HORSLEY 8216 OAKLEIGH RD. 21234</i>  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Peatery P. Dizon</i>  |  |   | DEGREE<br><i>M.D.</i>   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>7/9/86</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  |   | 23b. DATE<br><i>JULY 12, '86</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BELLAMY U.M. CHURCH</i>                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>GLOUCESTER, VIRGINIA</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>WILLIAM E. JOHNSON</i>  |  |   | 24b. ADDRESS<br><i>8521 LOCH RAVEN BLVD.</i>                                |   |  | 25a. DATE REC'D BY REGISTRAR<br><i>JUL 10 1986</i>   |   | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



0-14491

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19085

|  |  |  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
|--|--|--|--|---|--|--------------------------------------|--|---------------------------------|--|---|--|---|--|--------------------------------------|--|---------------------------|--|--|--|---|--|---|--|-------------------------|--|---------------------------|--|--------------------------|--|---|--|--------------------------|--|---------------------------|--|---|--|--|--|--------------------------|--|-------------------|--|---|--|--|--|-------------------|--|-------------------|--|-------------------|--|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH  |  | 2b. DATE OF ESTI-MATED  |  | 2c. DATE PRONOUNCED DEAD             |  | 2d. DATE OF DEATH               |  | 2e. DATE OF DEATH   |  | 2f. DATE OF DEATH   |  | 2g. DATE OF DEATH                    |  | 2h. DATE OF DEATH         |  | 2i. DATE OF DEATH  |  | 2j. DATE OF DEATH   |  | 2k. DATE OF DEATH   |  | 2l. DATE OF DEATH       |  | 2m. DATE OF DEATH         |  | 2n. DATE OF DEATH        |  | 2o. DATE OF DEATH   |  | 2p. DATE OF DEATH        |  | 2q. DATE OF DEATH         |  | 2r. DATE OF DEATH   |  | 2s. DATE OF DEATH                            |  | 2t. DATE OF DEATH        |  | 2u. DATE OF DEATH |  | 2v. DATE OF DEATH   |  | 2w. DATE OF DEATH                            |  | 2x. DATE OF DEATH |  | 2y. DATE OF DEATH |  | 2z. DATE OF DEATH |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH (MONTH DAY YEAR)    |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7. DATE OF BIRTH (MONTH DAY YEAR)   |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | 13a. STATE              |  | 13b. COUNTY               |  | 13c. CITY OR TOWN        |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |  | 14. FATHER'S NAME         |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT     |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                   |  |                   |  |                   |  |
| LESLIE Marie WALKER  |  | Female   |  | Cau.  |  | 6/15/1967                            |  | 19 YRS.                         |  | 6/15/1967   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | BALTIMORE COUNTY                     |  | Essex                     |  | Outer Loop 695 S. of Rt. 702                             |  | Agent   |  | Auto Leasing  |  | Maryland                |  | Baltimore                 |  | White Marsh              |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 11151 Philadelphia Road  |  | Robert Stanley Walker Jr. |  | Ruth Lee Hayes  |  | No   |  | 213-92-7833              |  | Ruth L. Walker    |  | same as above   |  | Multiple injuries                            |  |                   |  |                   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  | 13a. STATE                |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS     |  | 14. FATHER'S NAME         |  | 15. MOTHER'S MAIDEN NAME |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                        |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT             |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Maryland   |  | U.S.A.   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | BALTIMORE COUNTY                     |  | Essex                           |  | Outer Loop 695 S. of Rt. 702  |  | Agent   |  | Auto Leasing                         |  | Maryland                  |  | Baltimore  |  | White Marsh   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 11151 Philadelphia Road |  | Robert Stanley Walker Jr. |  | Ruth Lee Hayes           |  | No  |  | 213-92-7833              |  | Ruth L. Walker            |  | same as above   |  | Multiple injuries                            |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.             |  | 17. INFORMANT                   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Robert Stanley Walker Jr.  |  | Ruth Lee Hayes   |  | No  |  | 213-92-7833                          |  | Ruth L. Walker                  |  | same as above   |  | Multiple injuries   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Multiple injuries  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Conditions, any, which gave rise to immediate cause (a) stating the underlying cause last.   |  | (b)  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | (c)  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).        |  |  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH             |  | 21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR)   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
|  |  | 12 midnight 7-25-86  |  | driver of a pick-up truck which ran off the   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION OF INJURY (CITY OR TOWN, STREET, CITY OR TOWN, COUNTY, STATE)   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
|  |  | hwy.   |  | road down an embankment ejecting subject outer loop 695 S. of Rt. 702 Balto.Co., Md.  |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held on  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Margarita A. Korell, M.D.  |  | Assistant  |  | 7-26-86   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  | 111 Penn Street   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| Burial   |  | 7/29/1986  |  | Angel Hill Cem.   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| M. Gladden Kurtz   |  | Jarrettsville, Md.   |  | JUL 30 1986   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE   |  | 25d. REGISTRAR'S SIGNATURE  |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |
|  |  |  |  |   |  |                                      |  |                                 |  |   |  |   |  |                                      |  |                           |  |  |  |   |  |   |  |                         |  |                           |  |                          |  |   |  |                          |  |                           |  |   |  |  |  |                          |  |                   |  |   |  |  |  |                   |  |                   |  |                   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, (the medical examiner) the medical examiner must be notified by date.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |   |   |   |  | REG. NO. 86 19086                            |  |
|--|--|---|---|--|---|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |  |   |   |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE L. LAST WALKER   |  |   |   |  | 2a. DATE OF DEATH MONTH 7 DAY 14 YEAR 86  |   |   | 2b. HOUR 400 M  |  |  |  |
| 3. SEX FEMALE  |  | 4. RACE WHITE   |   | 5. DATE OF BIRTH MONTH 9 DAY 8 YEAR 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.                                       |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.                    |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH 21234  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERRING PARKWAY Nursing home |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER   |   | 12b. KIND OF BUSINESS OR INDUSTRY HOME                      |   |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND 21239   |  |   |   |  | 13b. CITY OR TOWN BALTIMORE   |   | 13c. STREET ADDRESS / ZIP CODE 1239 E. NORTHERN PKWY. 21239 |   |  |  |  |
| 14. FATHER'S NAME FIRST ROBERT MIDDLE E. LAST GATHER   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE GOBEL LAST   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO   |  | 16b. SOCIAL SECURITY NO. 212-07-7517  |   | 17. INFORMANT ADDRESS WILLIAM K. WALKER 21239 E. NORTHERN PKWY   |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe COPD  |  |   |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |  |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Pneumonia, Ischemic Heart Disease  |  |   |   |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |   |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |   |  | 22c. DATE SIGNED 7/16                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. E. JOHNSON  |  |   |   |  | 22e. ADDRESS 8521 LOCH RAVEN BLVD.  |   |   |   |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (15b) BURIAL  |  |   | 23b. DATE JULY 17, '86  |  | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY   |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD   |  |  |  |
| 24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON ADDRESS 8521 LOCH RAVEN BLVD.   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR JUL 16 1986   |   | 25b. REGISTRAR'S SIGNATURE                                  |   |  |  |  |

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MADE IN U.S.A.  
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVELYN MARY WALLS</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 5 86</b> |   |  | 2b. HOUR<br><b>10<sup>30</sup> AM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 21 20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Eastpoint Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |  |   |  |  |  |

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6848 Belclare Road 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Franck</b>                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Erva Pruitt</b>                             |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 215-12-0360</b> |  | 17. INFORMANT<br><b>Allan R. Walls</b>  |  | ADDRESS<br><b>9513 Hickory Hurst Dr. Balto., MD. 21236</b>        |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-15-86</b> to <b>7-5-86</b> , that (I) (we) last saw the deceased alive on <b>7-5-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>L.B. Jolley</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>7/5/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L.B. Jolley</b>  |  |  |  | 22e. ADDRESS<br><b>1812 Old North Point Rd Baltimore Md 21224</b>              |  |   |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>7/9/1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>        |  |                              |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 8 1986</b>                      |  |
|   |  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Swiden-Rodriguez</b>  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-11531

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 86 19088  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AUDREY RUTH WALSH  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 1 86   |  | 2b. HOUR<br>10:50PM  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Operator                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone Co.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>711 Maiden Choice lane Apt. 2128 21228   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bertram Gosnell  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth G. Kimber   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-22-7907   |  | 17. INFORMANT<br>ADDRESS<br>Apt. 2213 21228<br>Olin Henry Walsh 711 Maiden Choice Lane  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive Cardiac rupture</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>S. Arterio &amp; A. Hemorrhage</i> |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><i>Chronic Ischemic Heart Disease</i>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/4</i> 19 <i>86</i> to <i>7/1</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>6/30/86</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>John C. Healy</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>7/3/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John C. Healy   |  |  |  | 22e. ADDRESS<br>1311 Francis Avenue   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7/5/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>21229<br>JUL 17 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |  |  |  |




0-11592

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas Leo WATSON</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>7-5-86</b>   |  | 2b. HOUR<br><b>5:45A</b> M.  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 12 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Texas</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plant Supervisor</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE<br>13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Cockeysville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>300 International Circle 21030</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Leo Watson Sr.</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blanch M. Cromwell</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>551-07-2717</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Una Watson 300 International Circle 21030</b>                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>THORACIC AORTIC ANEURYSM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/4</b> , 19 <b>86</b> , to <b>7/5</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>7/5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>7/5/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. SMITH, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES STREET</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 8-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemt.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lutherville Baltimore Md.</b>                  |  | 23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 7 1986</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld</b>   |  |  |  | ADDRESS<br><b>6500 York Rd.</b>   |  |   |  |  |  |

BP



00-11927

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 0 9 0

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY CELESTE WAYNANT</b><br><i>Sr. Mary Celeste Waynant</i>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>9</b> YEAR <b>86</b>                          |   | 2b. HOUR<br><b>59</b><br><i>2 AM</i>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>26</b> YEAR <b>08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS <b>78</b>                    | IF UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>17</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b><br><i>Waukesha</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. county</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, Md.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RD-Sub Tech.</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>                           |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Waynant</b> LAST <b>Waynant</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mabel</b> MIDDLE <b>Waynant</b> LAST <b>Waynant</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-54-8398A</b>  |  | 17. INFORMANT ADDRESS<br><b>Sr. Louis Mary 2300 Dulaney Valley Road 21204</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Lymphoma, Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> , 19 <b>86</b> , to <b>7/9</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>7/9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Eddie Nakhuda</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>7/9/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie Nakhuda, M.D.</b>   |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>2300 Dulaney Valley Rd. - Towson, MD 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>7-11-86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1986</b>                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked accident (to be viewed by injury), or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1964

RECEIVED

0-12857

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 19091  
REG. NO.

|   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen C. WEBBER</b>                            |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 12, 1986</b>   |   | 2b. HOUR<br><b>10:26 pm</b>                        |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 12 17</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, MD.</b>   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John C. Kelley</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>--- Helen I. Pratt</b> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>020-20-6294</b>                             |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Thomas Webber - Same as #13</b>  |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Diabetes Mellitus**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7-12</b> , 19- <b>86</b> , to <b>7-12</b> , 19- <b>86</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>7-12</b> , 19- <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Dr. Frydenborg</i> MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-12-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Frydenborg</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr. 21237</b>  |  |   |  |

|  |  |                             |  |                                    |  |  |  |
|--|--|-----------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b> |  | 23b. DATE<br><b>7-13-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
|--|--|-----------------------------|--|------------------------------------|--|--|--|

|  |  |                               |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b> |  | ADDRESS<br><b>Balto., Md.</b> |  | 25. DATE RECEIVED BY REGISTRAR<br><b>JUL 21 1986</b> |  | 26. REGISTRAR'S SIGNATURE<br><i>Julia Dandon-Rudner</i> |  |
|--|--|-------------------------------|--|--|--|---|--|

1908

PAID TO ORDER

JUL 31 1908

00-11550

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Beatrice V. WEBSTER</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 2, 1986</b>                  |  |  | 2b HOUR<br><b>3:05a</b> M  |  |   |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 5 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Archibald Garrett</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Schlailie</b> |  |  | 13e STREET ADDRESS / ZIP CODE<br><b>2641 Liberty Parkway 21222</b>                   |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>212-10-0750</b>                              |  | 17 INFORMANT<br>ADDRESS<br><b>Paul E. Webster Same as 13e</b>  |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Breast Cancer</b>   |  |  |  |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a<br><b>Aortic Insufficiency</b>   |  |  |  |  |  |  |  |   |   |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 18</b> , 19 <b>86</b> , to <b>July 2</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>July 2</b> , 19 <b>86</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Larry Smith, MD</b>  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>7/2/86</b>   |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Larry Smith, M.D.</b>  |  |  |  |  | 22e ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b DATE<br><b>7/5/1986</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  |  |  |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 7 1986</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b> |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 item 1 is marked, the medical examiner must be notified at once.

BP

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

0271-1

RECEIVED JAN 10 1964

RECEIVED JAN 10 1964

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RECEIVED

00-11978

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove coroner's seal and return to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 9 0 9 3

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HAROLD WHEELLEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-7-86</b> |   |  | 2b. HOUR<br><b>4:01am</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-23-06</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer - G.W. Jackson Co.</b> |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2 SOUTH ERLY COURT, Apt. 403-21204</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM P WHEELLEY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AMELIA MANKO</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-7983</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Lula M. Wheelley - same as #13e</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac standstill</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>massive anterior MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Pneumonia + 1st fluid overload</b>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 24</b> , 19 <b>86</b> , to <b>July 8</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>July 8</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Vikramaditya Poonai</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>7/8/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VIKRAMADITYA POONAI</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES STREET 21204</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7-11-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto Md.</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1986</b>  |  |  |  |



0-12420

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 9 0 9 4  
REG. NO.FOR  
1- STATE  
REGISTRAR

|  |  |  |   |   |   |  |   |   |  |
|--|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Addie M. White  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-11-86                    |   |   | 2b. HOUR<br>6 <sup>00</sup> PM   |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5-19-01   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FOREST HAVEN NURSING HOME |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>BALTO.   |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD J. LACHER  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LORENIA J. ORWIG |   |   | 13e. STREET ADDRESS<br>5522 Carville Ave   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>217-24-9045                           |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Ruth M. Sprinkle - 5522 Carville Ave |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Cachexia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Rheumatoid Arthritis</u>  |  |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>   |  |  |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>84</u> , to <u>7-11</u> , 19 <u>86</u> , that (I/we) lost<br>saw the deceased alive on <u>7-10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) did (did not) view the body after death. |  |  |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Harold B. BOB</u>   |  |  |   | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>7-14-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold B. BOB   |  |  |   | 22e. ADDRESS<br>7220 Park Height 21208  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7-15-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEM.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO., MD.  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Gentry Miller - 7527 Hartford Rd.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 14 1986  |   | 25b. REGISTRAR'S SIGNATURE   |   |   |  |

MEDICAL CERTIFICATION

BP

20% COTTON



00-12768

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19095  
REG. NO.

|   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE</b>  |  | FIRST <b>GEORGE</b>   |  | MIDDLE <b>FULLER</b>  |  | LAST <b>WHITESIDE</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 16, 1986</b>                         |  | 2b. HOUR<br><b>12:13 P.M.</b>                         |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 12, 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH'S HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Adjuster</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4904 Alson Dr. 21229</b>                       |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Whiteside</b>               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ida Thweatt</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>WW1</b>                                   |  |
| 17. INFORMANT<br><b>Mrs. B.L. Tarnier</b>  |  | ADDRESS<br><b>1520 Kennewick Road 21218</b>                              |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>massive pneumonia</b>  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NIA</b> , 19____, to <b>NIA</b> , 19____, that (I) (we) last<br>saw the deceased alive on <b>NIA</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Adel S. El-Hennawy</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>7-16-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adel S. EL-Hennawy</b>   |  |  |  | 22e. ADDRESS<br><b>St. Joseph Hospital</b>   |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>7-21-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
|---|--|-----------------------------|--|---|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 18 1986</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |
|---|--|---|--|--|--|

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COTTON FIBER

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00-13074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19096

|   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
|---|--|---------|--|---|--|------------------------------------|--|--|--|--------------------------|--|---|--|---|--|-----------------------------------|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |         |  |   |  |                                    |  |  |  | 2a. DATE KNOWN OF DEATH  |  |   |  |   |  |                                   |  |  |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         |  |   |  |                                    |  |  |  | 2c. DATE OF DEATH        |  |   |  |   |  |                                   |  |  |  | 2d. HOUR |  |
| Alda Isabel Wilders   |  |         |  |   |  |                                    |  |  |  | 7 20 1986                |  |   |  |   |  |                                   |  |  |  | 0100     |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS          |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR  |  |                                   |  |  |  |          |  |
| Female  |  | white   |  | Oct 20 1909   |  | 76 YRS.                            |  | MONTHS DAYS HOURS MIN  |  |                          |  | 7 20 1986   |  | 1310  |  |                                   |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                                   |  |  |  |          |  |
| Md.   |  |         |  | USA   |  |                                    |  |  |  |                          |  | Baltimore county MD.  |  |   |  |                                   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                    |  |  |  |                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |          |  |
| Essex   |  |         |  | 320 S. Woodward Dr.   |  |                                    |  |  |  |                          |  | Housewife   |  |   |  |                                   |  |  |  |          |  |
| 13a. STATE  |  |         |  |   |  |                                    |  |  |  | 13b. CITY OR TOWN        |  | 13c. CITY LIMITS?   |  | 13d. STREET ADDRESS   |  |                                   |  |  |  |          |  |
| Md.   |  |         |  |   |  |                                    |  |  |  | Balto                    |  | Essex   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 320 S. Woodward 21221             |  |  |  |          |  |
| 14. FATHER'S NAME   |  |         |  |   |  |                                    |  |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |   |  |                                   |  |  |  |          |  |
| John Ashley Famous  |  |         |  |   |  |                                    |  |  |  | UNKNOWN                  |  |   |  |   |  |                                   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |         |  |   |  |                                    |  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS   |  |   |  |                                   |  |  |  |          |  |
| NO  |  |         |  |   |  |                                    |  |  |  | 163/38/9102              |  | Elmer Clouser 2513 lodge forest rd.                                 |  |   |  |                                   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| PART 1 DEATH WAS CAUSED BY:   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage</u>   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| (c)   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                    |  |  |  |                          |  | 20. AUTOPSY?  |  |   |  |                                   |  |  |  |          |  |
|   |  |         |  |   |  |                                    |  |  |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                                   |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
|   |  |         |  | P.M. 19   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                    |  | 21f. LOCATION  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
|   |  |         |  |   |  |                                    |  | STREET CITY OR TOWN COUNTY STATE   |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| ACTUAL SIGNATURE  |  |         |  | J. Crossan O'Donovan  |  |                                    |  | M.D. Deputy  |  |                          |  | DATE SIGNED   |  |   |  |                                   |  |  |  |          |  |
|   |  |         |  |   |  |                                    |  |  |  |                          |  | 7/20/86   |  |   |  |                                   |  |  |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  | J. CROSSAN O'DONOVAN  |  |                                    |  | ADDRESS  |  |                          |  | 2112 Dundalk Ave., Balto, Md. 21222                                 |  |   |  |                                   |  |  |  |          |  |
|   |  |         |  |   |  |                                    |  |  |  |                          |  |   |  |   |  |                                   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION            |  |   |  |   |  |                                   |  |  |  |          |  |
| Burial  |  |         |  | 7/24/86   |  | Wm. Walters Mem.                   |  |  |  | Coopstown Harford Md.    |  |   |  |   |  |                                   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |  |         |  |   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |  |                          |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                   |  |  |  |          |  |
| Connelly F. H. 300 Mace Ave.  |  |         |  |   |  |                                    |  | JUL 22 1986  |  |                          |  | John Davidson-Gardner   |  |   |  |                                   |  |  |  |          |  |

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

19097

REG. NO.

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret E Willenburg</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-23-86</b>                  |  |  | 2b. HOUR<br><b>9:17 P.M.</b>  |  |   |  |
| 1. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-18-06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Beecher</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Harriett Unknown</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-32-9943</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Joseph H. Willenburg 5015 Pilgrim Rd. 21214</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulm. edema 2nd to CHF</b>   |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD, CVA, colonic metastasis</b>   |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Kamal my-in</b>  |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>7-26-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |  |   |  | ADDRESS<br><b>5305 Harford Road</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>7/28/86</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical director must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

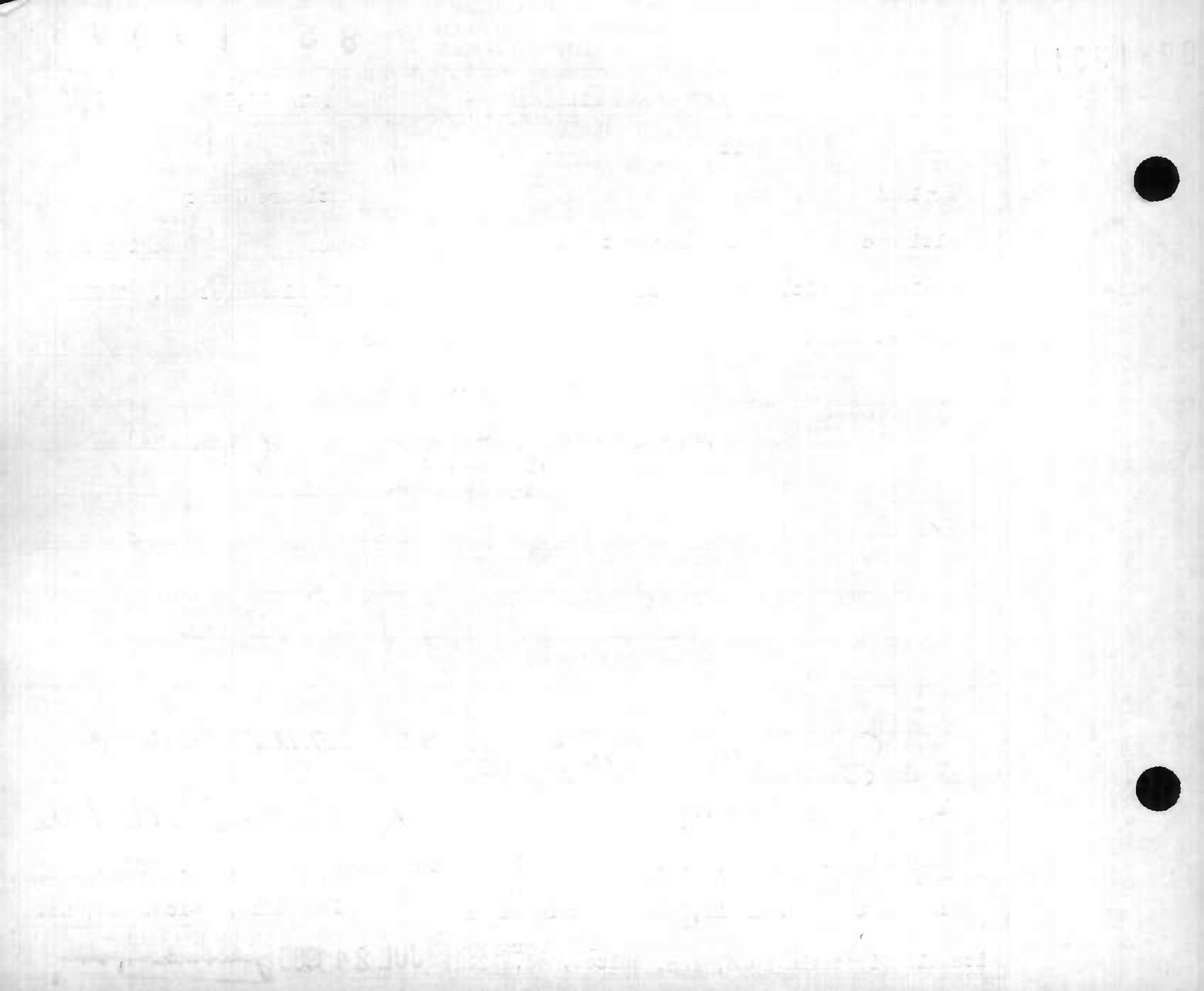
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REG. NO.

|  |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE HENRY CRANE WILLIAMS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 17, 1986</b>          |   |   | 2b. HOUR<br><b>7:32 PM</b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 25, 1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.              |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6423 Pinehurst Rd.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Machine Shop</b>      |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>                                      |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry A. Williams</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Geneva Crane</b> |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6423 Pinehurst Rd. 21212</b>                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-32-0804</b>  |  | 17. INFORMANT<br><b>Edna C. Crane</b>   |   | ADDRESS<br><b>Same</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malignant adenocarcinoma of prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostate</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast</u> |  |  |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>19</u>   |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6</u> 19 <u>85</u> , to <u>7/17</u> 19 <u>86</u> , that (1) (we) lost<br>saw the deceased alive on <u>7/17</u> 19 <u>86</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) (did) (did not) view the body after death.                         |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>B. K. Yorkoff, M.D.</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>7/18/86</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benjamin K. Yorkoff, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>7600 Osler Drive Towson, Md. 21204</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  |  | 23b. DATE<br><b>July 21, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Co., Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                      |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

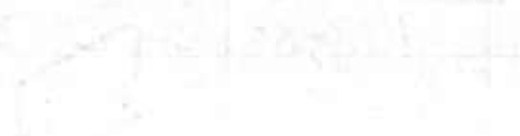
86 19099

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HENRIETTA E WILMORE   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 31 '86                 |  | 2b. HOUR<br>11:43A M  |
| 3. SEX<br>F   | 4. RACE<br>NEGRO  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 21  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13a. COUNTY Balt.   |   |   | 13b. CITY OR TOWN<br>Balt.                                       | 13c. STREET ADDRESS / ZIP CODE<br>2219 Pulaski St                                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR WHEELER  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EMILY MONROE   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>218-07-5332   |  | 17. INFORMANT<br>ADDRESS<br>Josephine Ridgely 516 Rosseter Dr                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOMA (METASTATIC)  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>8 MONTHS   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/16 19 86, to 7/31 19 86, that (I) (we) last saw the deceased alive on 7/31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br>Charles W. Emala MD   |   | DEGREE  |  | 22c. DATE SIGNED<br>7/31/86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES EMALA, M.D.  |   | 22e. ADDRESS<br>BMC - 6701 N. CHARLES STREET 21204  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>8/9/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Catholic Monks  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                           |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Locks Funeral Home  |   | ADDRESS<br>1304 p. Central Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 5 1986  |   |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Don Randall  |   |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4 may be

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 19109  
REG. NO.

|   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 7 17 86  |  |  | 6:33a M  |  |  |
| Margaret Elizabeth Wilson   |  |  |  |  |  |  |  |  |  |  |  |
| 3 SEX   |  |  | 4 RACE   |  |  | 5 DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |  |
| Female  |  |  | White  |  |  | MONTH DAY YEAR<br>7 2 25   |  |  | 61 YRS.  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |  |
| Balto., Md.   |  |  | U.S.A.   |  |  |  |  |  | Baltimore County MD.   |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b KIND OF BUSINESS OR INDUSTRY                               |  |  |
| Catonsville   |  |  | St. Martin's Home for the Aged   |  |  | grocery clerk  |  |  | Acme Markets   |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b STATE  |  |  | 13c CITY OR TOWN   |  |  | 13d INSIDE CITY LIMITS?  |  |  |
| Md.   |  |  | Balto.   |  |  | Baltimore  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 14 FATHER'S NAME  |  |  | 15 MOTHER'S MAIDEN NAME  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b SOCIAL SECURITY NO.  |  |  |
| John  |  |  | Ferber   |  |  | no   |  |  | 212-01-9687  |  |  |
|   |  |  |  |  |  | 17 INFORMANT   |  |  | ADDRESS  |  |  |
|   |  |  |  |  |  | Sr. Sharon   |  |  | 601 Maiden Choice Lane 21228                                   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Congestive heart failure  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Breast  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.  |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED   |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 21f LOCATION   |  |  | CITY OR TOWN COUNTY STATE                                      |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  | STREET   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-16-86 to 7-17-86, that (I) (we) last saw the deceased alive on 7-16-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |  |
| S. BASKARAN   |  |  |  |  |  | MD   |  |  | 7-17-86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e ADDRESS  |  |  |  |  |  |
| S. BASKARAN BASKARAN  |  |  |  |  |  | 3455 WILKENS AVE<br>BALTIMORE MD 21229   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION  |  |  |
| Cremation   |  |  | 7/17/86  |  |  | Security Process Inc   |  |  | Baltimore Co., Md.   |  |  |
| 24 FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| Dippel Funeral Home, Inc.<br>7110 Belair Road Baltimore, MD 21206   |  |  |  |  |  | JUL 18 1986  |  |  | John Davidson-Baskaran   |  |  |

BP



*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



00-12211

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 19101

|   |  |  |  |   |  |  |   |  |  |   |  |
|---|--|--|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETTIE Irene YEAGER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JULY 10, 1986</b>                   |   |  | 2b. HOUR<br>DAY MIN. <b>6:40 A.M.</b>  |   |  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 3, 1901</b>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY) <b>85</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE County MD.</b>                  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Resturant</b>  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Parkville</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3013 Lavender Avenue 21234</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Charles Walker</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Emma</b>                  |   |  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>215-12-8719</b> |   | 17. INFORMANT<br>ADDRESS <b>Baltimore MD.</b>                  |  |   | 17. INFORMANT<br><b>Helen I Briggs 3013 Lavender Avenue 21234</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Left Ventricular Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Symptomatic Scurvy</b> |  |  |  |   |  |  |   |  |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>          |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Beatrice P. Dizon, M.D.</b>  |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/10/86</b>                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Beatrice P D izon M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>St Joseph Hospital Towson, MD</b>                                 |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>7/12/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Dippel Funeral Home, Inc</b><br><b>7 110 Belair Road Baltimore, MD 21206</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 11 1986</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, or medical examination must be noted on this certificate.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 19102

|   |         |  |                                 |  |  |
|---|---------|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 2a. DATE OF DEATH MONTH DAY YEAR   |                                 | 2b. HOUR   |  |
| JOSEPH YEGANEH  |         | 07 29 '86  |                                 | 9:47A M  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR   |  |
| Male  | White   | MONTH DAY YEAR   | 07 05 86                        | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland  |         | USA  |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| TOWSON  |         | GREATER BALTIMORE MEDICAL CENTER 21204   |                                 | BALTIMORE COUNTY, MD.  |  |
| 13a. STATE  |         | 13b. CITY OR TOWN  |                                 | 13c. STREET ADDRESS / ZIP CODE   |  |
| Maryland  |         | Baltimore  |                                 | 1708 Aliceanna St. 21231   |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| Alireza   |         | Tina   |                                 | No   |  |
| 17. INFORMANT   |         | ADDRESS  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
| Tina Lawson   |         | 1708 Aliceanna St. 21231   |                                 | PART I. DEATH WAS CAUSED BY:   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | IMMEDIATE CAUSE (a) RENAL FAILURE  |  |
| 20a. AUTOPSY?   |         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                                 | DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK (ENTEROBACTERIACESE)   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |         | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                 | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/5 1986, to 7/29 1986, that (I) (we) last saw the deceased alive on 7/29 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |                                 | 22c. DATE SIGNED   |  |
| GARY KARLOWICZ, M.D.  |         | GBMC - 6701 N. CHARLES STREET 21204  |                                 | 7/29/86  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |         | 7/30/86  |                                 | New Cathedral Cemetery Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |                                 | 25b. REGISTRAR'S SIGNATURE   |  |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211   |         | JUL 30 1986  |                                 | Davidson-Randall   |  |

MEDICAL CERTIFICATION

601 P.



0-11975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_  
 DHMH - 16 60M 7/B4  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding parts. Part 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 86 19103  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <b>Lena Schmuck Zahrendt</b>  |  |   |  |   |  |  |  |  |  | *G. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lena Schmuck Zahrendt</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-7-86</b>                           |  |  | 2b. HOUR<br><b>1:10 AM</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-8-1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.         |  |   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA - MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County MD.</b>                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto., MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING TIME)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF MAKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christian J. Schmuck</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna J. Barnickol</b>      |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-5244</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Beverly E. Gray 4821 Westparkway 21229</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>             DUE TO, OR AS A CONSEQUENCE OF<br/>             (b) <b>hypoxia</b><br/>             DUE TO, OR AS A CONSEQUENCE OF<br/>             (c) <b>sepsis</b> </div> <div> <b>2nd to ARDS - Bil</b><br/> <b>Pneumonia, Renal failure</b> </div> </div> |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. Samuel ngin</b>  |  |   |  |   | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/7/86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22e. ADDRESS   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>07/09/1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                 |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 10 1986</b> |  |  |  |  |   |  |

REF ID: A67890

Belgium

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Approved: \_\_\_\_\_  
Special Agent in Charge

2576-50-713

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86-19104

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stanley ZUKER                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 27, 1986 |   |  | 2b. HOUR<br>3:35p M   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUC.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 20 1916  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stevadore   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley Zukowski                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leona Pozniak   |  | 13e. STREET ADDRESS / ZIP CODE<br>4802 Erdman Ave., Balto. 21205  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>212-09-4994  |  | 17. INFORMANT<br>ADDRESS<br>Ms. Frances Zuker - 4802 Erdman Ave. Balto. Md. 21205   |  |   |  |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Prostatic Cancer

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from June 15, 1986, to July 27, 1986, that (we) lost saw the deceased alive on July 27, 1986, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>I. Gouni, M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>July 27, 1986   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>I. Gouni, M.D.  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr. 21237   |  |   |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                     |  | 23b. DATE<br>7/30/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski - 1005 Dundalk Ave, 21224 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 31 1986 Julia Swanson |  |   |  |

